MONTANA LEGISLATIVE HISTORY

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H. Committee on Judiciary			S. Committee on Judiciary		
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Did this bill originate in an interim committee? ___Yes ___No

Committee _____ Report _____

Senate BILL NO. 377

INTRODUCED BY Cave Darko Roberts Brown Leitell Fabender Ryan Blaylock Conover Cetrone Romney

A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE FOR DETERMINATION AND TREATMENT OF THE SERIOUSLY MENTALLY ILL AND THOSE SUFFERING FROM MENTAL DISORDERS; AMENDING SECTIONS 38-110, 38-212, 38-506, 38-507, AND 80-1601; REPEALING SECTIONS 38-107, 38-108, 38-109, 38-112, 38-113, 38-114, 38-115, 38-116, 38-201, 38-202, 38-203, 38-204, 38-205, 38-206, 38-207, 38-208, 38-208.1, 38-208.2, 38-208.3, 38-209, 38-211, 38-213, 38-401, 38-402, 38-403, 38-404, 38-405, 38-406, 38-406.1, 38-406.2, 38-407, 38-408, 38-408.1, 38-502, 38-503, 38-504, 38-505, AND 64-112, R.C.M. 1947."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Purpose of act. The purpose of this act is:

(1) to secure for each person who may be seriously mentally ill or suffering from a mental disorder such care and treatment as will be suited to the needs of the person, and to insure that such care and treatment are skillfully and humanely administered with full respect for the person's dignity and personal integrity;

(2) to deprive a person of his liberty for purposes of

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treatment or care only when less restrictive alternatives are unavailable and only when his safety or the safety of others is endangered, and to provide for due process of law when this is done.

Section 2. Definitions. As used in this act:

(1) "Board" means the mental disabilities board of visitors created by this act.

(2) "Court" means the district court of the state of Montana.

(3) "Department" means the department of institutions.

(4) "Emergency situation" means a situation in which any person is in imminent danger of death or serious bodily harm from the activity of a person who appears to be seriously mentally ill.

(5) "Mental disorder" means any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions.

(6) "Mental health facility" or "facility" means a public hospital or a licensed private hospital or, a community mental health center, or any mental health clinic or treatment center approved by the department. No correctional institution or facility, or jail, is a mental health facility within the meaning of this act.

(7) "Next of kin" shall include, but need not be limited to, the spouse, parents, adult children, and adult

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brothers and sisters of a person.

(8) "Patient" means a person committed by the court to a seventy-two (72) hour evaluation or treatment or for a longer period.

(9) "Peace officer" means any sheriff, deputy sheriff, marshal, policeman or other peace officer.

(10) "Professional person" means:

(a) a medical doctor, or

(b) a person trained in the field of mental health and certified by the regional mental health director if the director is a licensed physician, or by the superintendent of the Montana state hospital, if the superintendent is a licensed physician, in the absence of such a regional director.

(11) "Respondent" means a person alleged in a petition filed pursuant to this act to be seriously mentally ill.

(12) "Responsible person" means any person willing and able to assume responsibility for a seriously mentally ill person, or person alleged to be seriously mentally ill, including next of kin; the person's conservator or legal guardian, if any; representatives of a charitable or religious organization, or any other person appointed by the court to perform the functions of a "responsible person" set out in this act. Only one person shall at any one time be the "responsible person" within the meaning of this act. In

appointing a responsible person, the court shall consider the preference of the respondent. The court may, at any time for good cause shown, change its designation of the "responsible person".

(13) "Seriously mentally ill" means suffering from a mental disorder which has resulted in self-inflicted injury or injury to others, or the imminent threat thereof; or which has deprived the person afflicted of the ability to protect his life or health. No person may be involuntarily committed to a mental health facility nor detained for evaluation and treatment because he is an epileptic, mentally deficient, mentally retarded, senile or suffering from a mental disorder unless the condition causes the person to be seriously mentally ill within the meaning of this act.

Section 3. Voluntary commitment — cost of commitment. (1) Nothing in this act shall be construed in any way as limiting the right of any person to make voluntary application for commitment at any time to any mental health facility or professional person. An application for admission to a mental health facility shall be in writing on a form prescribed by the facility and approved by the department of institutions. It shall not be valid unless it is approved by a professional person and a copy is given to the person voluntarily committing himself. The form shall

contain a statement of the rights of the person voluntarily committing himself, as set out in this act, including the right to release.

(2) Any person who wishes to voluntarily commit himself to the Montana state hospital shall first obtain certification from the regional mental health director of his mental health region or a professional person designated by the regional director that the person is suffering from a mental disorder and that the facilities available to the mental health region are unable to provide adequate evaluation and treatment.

(3) An application for voluntary commitment shall give the facility the right to detain the applicant for no more than five (5) days past his written request for release.

(4) The cost of involuntarily committing a patient who is voluntarily committed to a mental health facility at the time the involuntary proceedings are commenced shall be borne by the county of the patient's residence.

(5) The costs of transportation to a mental health facility under this section shall be provided by the patient, his parents, guardian, or the welfare department of the county of the patient's residence.

(6) Any person voluntarily entering or remaining in any mental health facility shall enjoy all the rights secured to a person involuntarily committed to the facility.

(7) Notwithstanding any other provision of law, a minor who is sixteen (16) years of age or older may consent to receive mental health services to be rendered by a facility or a person licensed to practice medicine or psychology in this state.

Section 4. Rights and waiver of rights. (1) Whenever a person is involuntarily detained, or is examined by a professional person pursuant to section 5, or is notified that he will be the subject of a hearing pursuant to section 5 or 6, the person shall be informed of his constitutional rights and his rights under this act. A person may waive his procedural rights, provided that the waiver is knowingly and intentionally made. The right to counsel in a hearing held pursuant to section 6 may not be waived. The right to treatment provided for in this act may not be waived.

(2) In the case of a person who has been committed for a seventy-two (72) hour inpatient evaluation and treatment or for a longer period of time, a waiver of rights can be knowingly and intentionally made only with the concurrence of the patient's attorney or of the responsible person appointed by the court.

(3) In the case of a minor, the waiver of rights can be knowingly and intentionally made

(a) when the minor is under the age of twelve (12), by the parents of the minor;

according to the rules of evidence applicable to civil matters generally;

(g) the right to view and copy all petitions on file with the court concerning him;

(h) the right to be examined by a professional person of his choice when such professional person is reasonably available;

(i) the right to be dressed in his own clothes at any hearing held pursuant to this act;

(j) the right to refuse any but lifesaving medication for up to twenty-four (24) hours prior to any hearing held pursuant to this act.

Section 5. Petition alleging person as seriously mentally ill - contents and procedure. (1) A county attorney on his own initiative or upon the request of any person may file a petition with the court alleging that there is a person within the county who is seriously mentally ill and requesting that an evaluation of the person's condition be made.

(2) The petition shall contain:

(a) the name and address of the person requesting the petition and his interest in the case;

(b) the name of the respondent, and, if known, the address, age, sex, marital status, and occupation of the respondent;

(b) when the minor is over the age of twelve (12), by the youth and his parents;

(c) when the minor is over the age of twelve (12) and the minor and his parents do not agree, the minor can make an effective waiver of his rights only with advice of counsel.

If there is a conflict of interest between a minor and his parents or guardian, the court may appoint a guardian ad litem for the minor.

(4) In addition to any other rights which may be guaranteed by the constitution of the United States and of this state, by the laws of this state or by this act, any person who is involuntarily detained or against whom a petition is filed pursuant to this act has the following rights:

(a) the right to notice reasonably in advance of any hearing or other court proceeding concerning him;

(b) the right in any hearing to be present, to offer evidence, and to present witnesses in any proceeding concerning him;

(c) the right in any hearing to cross-examine witnesses;

(d) the right to be represented by counsel;

(e) the right to remain silent;

(f) the right in any hearing to be proceeded against

(c) the purported facts supporting the allegation of mental illness;

(d) the name and address of every person known or believed to be legally responsible for the care, support, and maintenance of the person for whom evaluation is sought;

(e) the name and address of the person's next of kin, to the extent known to the county attorney and the person requesting the petition;

(f) the name and address of any person whom the county attorney believes might be willing and able to be appointed as responsible person;

(g) the name, address, and telephone number of the attorney, if any, who has most recently represented the person for whom evaluation is sought. If there is no attorney, there shall be a statement as to whether, to the best knowledge of the person requesting the petition, the person for whom evaluation is sought is indigent and therefore unable to afford the services of an attorney; and

(h) a statement of the rights of the respondent which shall be in conspicuous print and identified by a suitable heading.

(3) Upon presentation to the court by the county attorney, the court shall immediately consider the petition with or without a hearing to determine if there is probable cause to believe that the respondent is seriously mentally

ill. If the court finds no such probable cause, the petition shall be discharged. If the court finds probable cause it shall submit the petition to a professional person for evaluation. If probable cause is found, the court may appoint a responsible person to protect the interests of the respondent. The responsible person shall be notified as soon as possible that a petition has been filed. Notice of the petition and the finding of probable cause shall be hand delivered or mailed to the respondent and to the attorney, the person or persons legally responsible for care, support, and maintenance of the respondent, next of kin identified in the petition, and the person or persons identified by the county attorney as possible responsible persons.

(4) (a) Upon receipt of the petition, the professional person shall examine the respondent and make such inquiry as he or she may deem appropriate. If the respondent does not cooperate and if requested by the professional person, the court may order the respondent to submit to examination by a professional person at a time and place designated by the court. The examination so ordered shall not exceed a period of four (4) hours.

(b) When the professional person first contacts the respondent, before he begins any examination, he shall give a copy of the petition to the respondent, and shall explain to the respondent the nature of the proceeding and his

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rights as set forth in the petition.

(5) On the basis of his examination, the professional person shall recommend in writing either that the petition be dismissed or that a seventy-two (72) hour inpatient evaluation and treatment be ordered. If dismissal is recommended, the petition shall be summarily dismissed. The petition shall be dismissed if the respondent accepts voluntary treatment or commitment to a mental health facility approved by the professional person conducting the examination. Whenever a professional person recommends that a seventy-two (72) hour evaluation and treatment be ordered, the recommendation shall be accompanied by a report explaining the reason for the recommendation and identifying any tests or evaluation devices which the professional person employed in evaluating the respondent. If the professional person recommends that a seventy-two (72) hour evaluation and treatment be ordered, notice of this recommendation shall be mailed or delivered to the respondent, the next of kin, when known, any person responsible for the care, support, and maintenance of the respondent, any other person identified in the petition, and the responsible person, if any, appointed by the court. Notice shall include the date, time, and place of the respondent's next appearance before the court.

(6) In the event the examining professional person

recommends a seventy-two (72) hour inpatient evaluation and treatment, the respondent shall be brought before the court by the county attorney without undue delay, advised of the recommendation, supplied with a copy of the petition and the recommendation and advised of his rights to a hearing and to counsel. If a responsible person has not yet been appointed, the court shall appoint a responsible person at this time. If the right to a hearing and to counsel are waived, the court shall direct that the respondent be detained at a mental health facility for evaluation and treatment not to exceed seventy-two (72) hours. If a hearing is requested by the respondent, his attorney, or the responsible person appointed by the court, a time and place shall be set for the hearing. The matter shall be given precedence over all other court matters. If the respondent is unwilling or unable to retain counsel, the court shall appoint counsel and be responsible for notification.

(7) The hearing shall be held before the court without a jury. The respondent may present such testimony and relevant documentary evidence as he or the responsible person or counsel desires. The county attorney shall represent the state. The professional person who made the recommendation shall be present in court and may be cross-examined concerning his recommendation and his report. After full hearing the court shall determine whether the

respondent is seriously mentally ill within the definition provided herein. If the court finds the respondent is not seriously mentally ill, he or she shall be discharged and the petition dismissed. If the court finds the respondent to be seriously mentally ill, it shall order the respondent detained at a mental health facility for examination and treatment not exceeding seventy-two (72) hours. However, the court may dismiss the petition if the respondent agrees to accept voluntary treatment or commitment to a mental health facility.

(8) Persons receiving evaluation and treatment pursuant to this section shall be given a reasonable choice of an available professional person qualified to provide such services.

Section 6. Petition for commitment — trial — determination of court. (1) If in the opinion of the professional person in charge of the patient the person detained under the provisions of section 5 of this act does not require further evaluation or treatment he shall be released within seventy-two (72) hours. If, in the opinion of the professional person, the patient requires further evaluation or treatment, he shall advise the court accordingly not less than three (3) days from the date of detention and shall within the same time file a petition requesting that the patient be committed to a facility for a

period not in excess of three (3) months. The petition shall be accompanied by a written report and evaluation of the patient's mental and physical condition. The report shall explain the reasons for the petition and shall identify any tests or evaluation devices which the professional person employed in evaluating the patient. The professional person may retain custody of the patient pending a hearing on the petition only if detention is necessary to prevent injury to himself or others.

(2) Upon receipt of a petition for commitment not to exceed three (3) months, the court shall immediately set the time and place for a hearing, which shall be held not more than three (3) days from the receipt of the petition. The court may extend the period to seven (7) days. The time for the hearing may be further extended at the request of counsel for the patient. The court shall give written notice to the professional person who requested the commitment, the patient, his counsel, his next of kin, when known, the responsible person appointed by the court, and the county attorney. At any time prior to the date set for hearing, the patient, or his attorney, may request a jury trial, whereupon the time set for hearing will be vacated and the matter set on the court's jury calendar at the earliest date possible, the matter taking precedence over all other matters on the jury calendar.

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(3) At any time prior to trial on the petition before court or jury, the patient may waive trial and give written consent to commitment to a facility for a period not to exceed three (3) months. Such consent must be joined in writing, by his attorney and by the responsible person appointed by the court.

(4) The patient shall be present and represented by counsel at all stages of the trial, and the sole question to be determined by the court or jury, as the case may be, shall be whether the patient is seriously mentally ill within the meaning set forth in this act. The professional person who filed the petition shall be present in court for the hearing and subject to cross-examination. The trial shall be governed by the Montana rules of civil procedure except that, if tried by a jury, at least three-fourths (3/4) of the jurors must concur on a finding that the patient is seriously mentally ill. The finding may be appealed to the Montana supreme court in the same manner as other civil matters. The standard of proof in any hearing held pursuant to this section shall be proof beyond a reasonable doubt.

(5) If, upon hearing, it is determined that the patient is not seriously mentally ill within the meaning of this act, he shall be discharged and the petition of the professional person dismissed. If it is determined that the

patient is seriously mentally ill within the meaning of this act the court shall:

(a) commit the patient to a facility for a period of not more than three (3) months;

(b) order the patient to be placed in the care and custody of his relative or guardian or some other appropriate place other than an institution;

(c) order outpatient therapy; or

(d) make some other appropriate order for treatment. No treatment ordered pursuant to this subsection shall affect the patient's custody for a period of more than three (3) months.

In determining which of the above alternatives to order, the court shall choose the least restrictive alternatives necessary to protect the patient and the public and to permit effective treatment. The court shall consider and shall describe in its order what alternatives for treatment of the patient are available, what alternatives were investigated and why the investigated alternatives were not deemed suitable.

At any time within the three (3) month period the patient may be discharged on the written order of the professional person in charge of the patient. In the event the patient is not discharged within the three (3) month period and if the term is not extended as provided herein,

the patient will be discharged by the facility at the end of three (3) months without further order of the court. Notice of such discharge will be filed with the court within five (5) days of the discharge.

(6) Not less than two (2) calendar weeks prior to the end of the three (3) month period of detention, the professional person in charge of the patient may petition the court for extension of the detention period. The petition shall be accompanied by a written report and evaluation of the patient's mental and physical condition. The report shall describe any tests and evaluation devices which have been employed in evaluating the patient, the course of treatment which has been undertaken for the patient and the future course of treatment anticipated by the professional person. Upon the filing of the petition, the court shall give written notice of the filing of the petition to the patient, his next of kin, if reasonably available, the responsible person appointed by the court, and to the patient's counsel. If any person so notified requests a hearing prior to the termination of the previous detention authority the court shall immediately set a time and place for such a hearing on a date not more than ten (10) days from the receipt of the request and notify the same people including the professional person in charge of the patient. Procedure on the petition for extension shall

be the same in all respects, as the procedure on the petition for the original three (3) month commitment save and except the patient shall not be entitled to trial by jury. The hearing shall be held in the district court having jurisdiction over the facility in which the patient is detained unless otherwise ordered by the court. If upon the hearing the court finds the patient to be not seriously mentally ill within the meaning of this act, the patient shall be discharged and the petition dismissed. If the court finds that the patient continues to suffer from such serious mental illness, the court shall order commitment, custody in relatives, outpatient therapy or other order as set forth in subsection (5) of this section except that no order shall affect his custody for more than six (6) months. In its order, the court shall describe what alternatives for treatment of the patient are available, what alternatives were investigated, and why the investigated alternatives were not deemed suitable. The court shall not order continuation of an alternative which does not include a comprehensive, individualized plan of treatment for the patient. Any court order for the continuation of an alternative shall include a specific finding that a comprehensive, individualized plan of treatment exists.

(7) Further extensions may be obtained under the same procedure described in subsection (6) of this section except

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that the patient's custody shall not be affected for more than one (1) year, without a renewal of the commitment under the procedures set forth in subsection (6) of this section, including a statement of the findings required by subsection (6).

(8) At any time during the patient's commitment the court may on its own initiative or upon application of the professional person in charge of the patient, the patient, his next of kin, his attorney, or the responsible person appointed by the court, order the patient to be placed in the care and custody of relatives or guardians, or to be provided outpatient therapy or other appropriate placement or treatment.

Section 7. Emergency situation — petition — detention. (1) When an emergency situation exists, a peace officer may take any person who appears to be seriously mentally ill and, as a result of serious mental illness, to be a danger to others or to himself into custody only for sufficient time to contact a professional person for emergency evaluation. If possible, a professional person should be called prior to taking the person into custody.

(2) If the professional person agrees that the person detained appears to be seriously mentally ill and that an emergency situation genuinely exists, then the person may be detained until the next regular business day. At that time,

the professional person shall either cause the county attorney to file the petition provided for in section 5 of this act or shall release the detained person. In either case, the professional person shall file a report with the court explaining his actions.

(3) When the petition is filed, after an emergency detention, the court may order the respondent detained for the amount of time necessary for a professional person to conduct the examination and inquiry provided for in section 5 and to report his findings and recommendations to the court. In no case shall such detention exceed twenty-four (24) hours from the time of the filing of the petition. Saturday, Sunday, and legal holidays shall not be included in computing the twenty-four (24) hour period. The court may also order the respondent detained during the seventy-two (72) hour evaluation and treatment period, if ordered, and through the period of the hearing on initial commitment, if held. No period of detention shall be ordered by the court pursuant to this section unless the court finds that such detention is required in the interest of public safety. An order of detention shall include a statement of the factual basis for the order.

(4) Any person detained pursuant to this section shall be detained in the least restrictive environment required to protect the life and physical safety of the person detained

or of members of the public. Whenever possible, a person detained pursuant to this section shall be detained in a mental health facility. A person may be detained in a jail or other correctional facility only if no mental health facility is available or if the available mental health facilities are inadequate to protect the person detained and the public. As soon as a mental health facility becomes available or the situation has changed sufficiently that an available mental health facility is adequate for the protection of the person detained and of the public, then the detained person shall be transferred from the jail or correctional facility to the mental health facility. In no case shall a person be detained in a jail or other correctional facility pursuant to this section for a longer period of time than is required for the county attorney to file a petition and for a professional person to complete his initial examination and inquiry and report his findings to the court.

(5) The county attorney of any county may make arrangements with any federal, state, regional, or private mental facility or with a mental health facility in any county for the detention of persons held pursuant to this section.

Section 8. Outpatient care — conditional release. (1) When in the opinion of the professional person in

charge of a mental health facility providing involuntary treatment, the committed person can be appropriately served by outpatient care prior to the expiration of the period of commitment, then such outpatient care may be required as a condition for early release for a period which, when added to the inpatient treatment period, shall not exceed the period of commitment. If the mental health facility designated to provide outpatient care is other than the facility providing involuntary treatment, the outpatient facility so designated must agree in writing to assume such responsibility.

(2) The mental health facility designated to provide outpatient care or the professional person in charge of the patient's case may modify the conditions for continued release when such modification is in the best interest of the patient.

(3) If the mental health facility designated to provide outpatient care determines that a conditionally released person is failing to adhere to the terms and conditions of his release, and because of that failure has become a substantial danger to himself or other persons, then, upon notification by the mental health facility designated to provide outpatient care, or on his own motion, the professional person in charge of the patient's case may order that the conditionally released person be apprehended

and taken into custody and temporarily detained in a mental health facility in or near the county in which he is receiving outpatient treatment until such time, not exceeding five (5) days, as a hearing can be scheduled to determine whether or not the person should be returned to the mental health facility from which he had been conditionally released. The professional person in charge of the patient's case may modify or rescind such order at any time prior to commencement of the court hearing. The court shall be notified before the close of the next judicial day of a person's detention under the provisions of this section, and the county attorney of the county where the patient is receiving outpatient treatment shall file a petition and order of apprehension and detention with the court and mail or deliver notice to the person detained, his attorney, if any, and his guardian or conservator, if any, his next of kin, if known, and the responsible person appointed by the court. Such person shall have the same rights with respect to notice, hearing, and counsel as for an involuntary commitment proceeding, except as specifically set forth in this section and except that there shall be no right to jury trial. The issues to be determined shall be whether the conditionally released person did or did not adhere to the terms and conditions of his release; and, if he failed to adhere to such terms and conditions, (a)

whether he is likely to injure himself or other persons if not returned for involuntary treatment on an inpatient basis, or (b) whether the conditions of release should be modified. Pursuant to the determination of the court upon such hearing, the conditionally released person shall either continue to be conditionally released on the same or modified conditions or shall be returned for involuntary treatment on an inpatient basis subject to release at the end of the period for which he was committed for involuntary treatment, or otherwise in accordance with the provisions of this act. Such hearing may be waived by the person and his counsel and the responsible person, but shall not be waivable unless all such persons agree to waive, and upon such waiver the person may be returned for involuntary treatment or continued on conditional release on the same or modified conditions.

(4) The proceedings set forth in subsection (3) of this section may be initiated by the professional person in charge of the patient's case on the same basis set forth therein without the professional person requiring or ordering the apprehension and detention of the conditionally released person, in which case the court hearing shall take place in not less than fifteen (15) days from the date of service of the petition upon the conditionally released person.

Upon expiration of the period of commitment, or when the person is released from outpatient care, notice in writing to the court which committed the person for treatment shall be provided.

Section 9. Right to counsel and appeal — examination of respondent — records. (1) The person alleged to be seriously mentally ill shall be present at any hearing or trial. If he has no attorney, the judge shall appoint an attorney to represent him at either the hearing or the trial or both. If the court determines that the respondent is financially unable to employ an attorney, the court shall appoint counsel who shall be compensated from the public funds of the county where the respondent resides. The county of residence shall also pay all precommitment expenses including transportation to a mental health facility incurred in connection with the arrest, examination, and precommitment custody.

(2) The respondent, his attorney, or the responsible person appointed by the court may secure a professional person of his own choice to examine the respondent and to testify at the hearing before the court or jury as to the results of his examination.

(3) If the person wishing to secure the testimony of a professional person is unable to do so because of financial reasons, and if the respondent joins in the request for such

examination, the court shall appoint a professional person other than the professional person requesting the commitment to perform the examination. Whenever possible, the court shall allow the respondent a reasonable choice of an available professional person qualified to perform the requested examination.

(4) Every respondent subject to an order for short-term treatment or long-term care and treatment shall be advised of his right to appeal such order by the court at the conclusion of any hearing as a result of which such an order may be entered.

(5) Records and papers in proceedings under this act shall be maintained separately by the clerks of the several courts. Upon the release of any respondent or patient, the facility shall notify the clerk of the court within five (5) days of the release, and the clerk shall immediately seal the record in the case and omit the name of the respondent or patient from the index or indices of cases in such court until and unless the court orders hem opened for good cause shown.

Section 10. Transfer or commitment to facility — procedure. No person who is in the custody of the department of institutions for any purpose other than treatment of severe mental illness shall be transferred or committed to a mental health facility unless such transfer

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or commitment is effected according to the procedures set out in this act.

Section 11. Appeal procedure. Appellate review of any order of short-term treatment or long-term care and treatment may be had by appeal to the supreme court of Montana in the manner as other civil cases. The patient shall not be released pending appeal unless ordered by the court. The appeal shall have priority above all other matters before the supreme court.

Section 12. Effect of act on persons currently judged mentally ill. Any person who, by reason of a judicial decree entered by a court of this state prior to the enactment of this act adjudicating such person mentally ill shall, one (1) year following the effective date of this act be deemed to have been released and restored to legal capacity and competency unless, before that time, a petition for an extended detention order is filed with the court.

Section 13. Civil and legal rights of person committed. (1) Unless specifically stated in an order by the court, a person involuntarily committed to a facility for a period of evaluation or treatment shall not forfeit any legal right or suffer any legal disability by reason of the provisions of this act except insofar as it may be necessary to detain the person for treatment, evaluation or care.

(2) Whenever any person is committed to a mental health facility for a period of three (3) months or longer, the court ordering the commitment may make an order stating specifically any legal rights which are denied the respondent and any legal disabilities which are imposed on him. As part of its order, the court may appoint a person to act as conservator of the respondent's property. Any conservatorship created pursuant to this section shall terminate upon the conclusion of the involuntary commitment if not sooner terminated by the court. A conservatorship or guardianship extending beyond the period of involuntary commitment may not be created except according to the procedures set forth under Montana law for the appointment of conservators and guardians generally.

(3) Any person who has been committed to a mental health facility pursuant to this act shall be automatically restored upon the termination of the commitment to all of his civil and legal rights which may have been lost when he was committed. This subsection shall not affect, however, any guardianship or conservatorship created independently of the commitment proceedings, according to the provisions of Montana law relating to the appointment of conservators and guardians generally. Any person who leaves a mental health facility following a period of evaluation and treatment shall be given a written statement setting forth the

substance of this subsection.

(4) Any person committed to a mental health facility prior to the effective date of this act shall enjoy all the rights and privileges of a person committed after the effective date of this act.

(5) No person who has received evaluation or treatment under any provisions of this act shall be discriminated against because of such status. For purposes of this section, "discrimination" means giving any unfavorable weight to the fact of hospitalization or outpatient care and treatment unrelated to a person's present capacity to meet standards applicable to all persons. The fact that a person has received evaluation and treatment, whether voluntarily or involuntarily, at any mental health facility shall not be admitted into evidence in any subsequent proceeding for involuntary commitment or for the appointment of a guardian or conservator.

Section 14. Transfer of person committed. (1) If a person is committed under the provisions of this act and is eligible for hospital care or treatment by an agency of the United States, and if a certificate of notification from such agency showing that facilities are available and that the person is eligible for care or treatment therein is received, the court may order the person to be placed in the custody of the agency for hospitalization. The chief

officer of any hospital or institution operated by such an agency and in which a person is so hospitalized shall, be vested with the same powers as the superintendent of the Montana state hospital with respect to detention, custody, transfer, conditional release, or discharge of the person. Jurisdiction shall be retained in the appropriate courts of this state to inquire into the mental condition of persons so hospitalized, and to determine the necessity for continuance of their hospitalization.

(2) Consistent with other provisions of this act, a person committed under this act for a period of three (3) months or longer may be committed by the court to the custody of friends or next of kin residing outside the state or to a mental health facility located outside the state, if the out-of-state facility agrees to receive the patient, provided, however, that no such commitment shall be for a longer period of time than is permitted within the state. If the patient is indigent, the expense of supporting him in an out-of-state facility and the expense of transportation shall be born by the state of Montana.

(3) The transfer of persons committed under the provisions of this act out of Montana or under the laws of another jurisdiction into Montana shall be governed by the provisions of the interstate compact on mental health.

Section 15. Fingerprinting prohibited. No person

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admitted to or in a mental health facility shall be fingerprinted unless required by other provisions of law.

Section 16. Photographs permitted — confidential. (1) A person admitted to a mental health facility may be photographed upon admission for identification and the administrative purposes of the facility. Such photographs shall be confidential and shall not be released by the facility except pursuant to court order.

(2) No other nonmedical photographs shall be taken or used without consent of the patient's legal guardian or the responsible person appointed by the court.

Section 17. Rights of persons admitted to facility. Patients admitted to a mental health facility, whether voluntarily or involuntarily, shall have the following rights:

(1) Patients have a right to privacy and dignity.

(2) Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment.

(3) Patients shall have the same rights to visitation and reasonable access to private telephone communications as patients at any public hospitals, except to the extent that the professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. The written order must be renewed after each periodic review of the treatment plan if any

restrictions are to be continued. Patients shall have an unrestricted right to visitation with attorneys, with spiritual counsellors, and with private physicians and other professional persons.

(4) Patients shall have an unrestricted right to send sealed mail. Patients shall have an unrestricted right to receive sealed mail from their attorneys, private physicians, and other professional persons, from the mental disabilities board of visitors, from courts, and government officials. Patients shall have a right to receive sealed mail from others, except to the extent that a professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions on receipt of sealed mail. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued.

(5) Patients have an unrestricted right to have access to letter writing materials, including postage, and have a right to have staff members of the facility assist persons who are unable to write, prepare, and mail correspondence.

(6) Patients have a right to wear their own clothes and to keep and use their own personal possessions including toilet articles, except insofar as such clothes or personal possessions may be determined by a professional person in charge of the patient's treatment plan to be dangerous or

otherwise inappropriate to the treatment regimen. The facility has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable clothing of their own. Patients shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the patient's throughout his stay at the facility. The facility shall make provision for the laundering of patient clothing.

(7) Patients have the right to keep and be allowed to spend a reasonable sum of their own money.

(8) Patients have the right to religious worship. Provisions for such worship shall be made available to all patients on a nondiscriminatory basis. No individual shall be required to engage in any religious activities.

(9) Patients have a right to regular physical exercise several times a week. Moreover, it shall be the duty of the facility to provide facilities and equipment for such exercise. Patients have a right to be outdoors at regular and frequent intervals, in the absence of medical considerations.

(10) Patients have the right to be provided with adequate supervision, suitable opportunities for interaction with members of the opposite sex, except to the extent that a professional person in charge of the patient's treatment plan writes an order stating that such interaction is

inappropriate to the treatment regimen.

(11) Patients have a right to receive prompt and adequate medical treatment for any physical ailments. In providing medical care, the mental health facility shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the patient's treatment for mental illness with his medical treatment.

(12) Patients have a right to a diet that will provide at a minimum the recommended daily dietary allowances as developed by the national academy of sciences. Provisions shall be made for special therapeutic diets and for substitutes at the request of the patient, or the responsible person, in accordance with the religious requirements of any patient's faith. Denial of a nutritionally adequate diet shall not be used as punishment.

(13) Patients have a right to a humane psychological and physical environment within the mental health facilities. These facilities shall be designed to afford patients with comfort and safety, promote dignity, and ensure privacy. The facilities shall be designed to make a positive contribution to the efficient attainment of the treatment goals set for the patient. In order to assure the accomplishment of this goal:

(a) Regular housekeeping and maintenance procedures which will ensure that the facility is maintained in a safe,

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clean, and attractive condition shall be developed and implemented.

(b) There must be special provision made for geriatric and other nonambulatory patients to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory patients to communicate their needs to the facility staff.

(c) Pursuant to an established routine maintenance and repair program, the physical plant of every facility shall be kept in a continuous state of good repair and operation in accordance with the needs of the health, comfort, safety, and well-being of the patients.

(d) Every facility must meet all fire and safety standards established by the state and locality. In addition, any hospital shall meet such provisions of the Life Safety Code of the national fire protection association as are applicable to hospitals. Any hospital shall meet all standards established by the state for general hospitals, insofar as they are relevant to psychiatric facilities.

Section 18. Patient labor — rules. The following rules shall govern patient labor:

(1) No patient shall be required to perform labor which involves the operation and maintenance of a facility or for which the facility is under contract with an outside

organization. Privileges or release from the facility shall not be conditioned upon the performance of labor covered by this provision. Patients may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. sec. 206 as amended.

(2)(a) Patients may be required to perform therapeutic tasks which do not involve the operation and maintenance of the facility, provided the specific task or any change in assignment is:

(i) An integrated part of the patient's treatment plan and approved as a therapeutic activity by a professional person responsible for supervising the patient's treatment; and

(ii) Supervised by a staff member to oversee the therapeutic aspects of the activity.

(b) Patients may voluntarily engage in therapeutic labor for which the facility would otherwise have to pay an employee, provided the specific labor or any change in labor assignment is:

(i) An integrated part of the patient's treatment plan and approved as a therapeutic activity by a professional person responsible for supervising the patient's treatment; and

(ii) Supervised by a staff member to oversee the

therapeutic aspects of the activity; and

(iii) Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. sec. 206 as amended.

(3) If any patient performs therapeutic labor which involves the operation and maintenance of a facility, but due to physical or mental disability is unable to perform the labor as efficiently as a person not so physically or mentally disabled, then the patient may be compensated at a rate which bears the same approximate relation to the statutory minimum wage as his ability to perform that particular job bears to the ability of a person not so afflicted.

(4) Patients may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.

(5) Patients shall be allowed to use a reasonable amount of the compensation received pursuant to this section for personal and incidental purchases and expenses.

Section 19. Medication for patients. Patients have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. The professional person in charge of the facility and the attending physician shall be responsible for all medication given or administered to a

patient. The use of medication shall not exceed standards of use that are advocated by the United Stated food and drug administration. Notation of each individual's medication shall be kept in his medical records. At least weekly an attending physician shall review the drug regimen of each patient under his care. All prescriptions shall be written with a termination date, which shall not exceed thirty (30) days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the patient's treatment program.

Section 20. Physical restraint and isolation. Patients have a right to be free from physical restraint and isolation. Except for emergency situations, in which it is likely that patients could harm themselves or others and in which less restrictive means of restraint are not feasible, patients may be physically restrained or placed in isolation only on a professional person's written order which explains the rationale for such action. The written order may be entered only after the professional person has personally seen the patient concerned and evaluated whatever episode or situation is said to call for restraint or isolation. Emergency use of restraints or isolation shall be for no more than one (1) hour, by which time a professional person shall have been consulted and shall have entered an

appropriate order in writing. Such written order shall be effective for no more than twenty-four (24) hours and must be renewed if restraint and isolation are to be continued. Whenever a patient is subject to restraint or isolation, adequate care shall be taken to monitor his physical and psychiatric condition and to provide for his physical needs and comfort.

Section 21. Research on patients — restrictions. Patients shall have a right not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give such consent, and of his guardian, if any, and the responsible person appointed by the court, after opportunities for consultation with independent specialists and with legal counsel. If there is no responsible person or if the responsible person appointed by the court is no longer available, then a responsible person who is in no way connected with the facility, the department of institutions, or the research project shall be appointed prior to the involvement of the patient in any experimental research. The facility shall send notice of intent to involve the patient in experimental research to the patient, his next of kin, if known, his legal guardian, if any, the attorney who most recently represented him, and the responsible person appointed by the court at least ten (10) days prior to the

commencement of such experimental research.

Such proposed research shall first have been reviewed and approved by the mental disabilities board of visitors before such consent shall be sought. Prior to such approval the board shall determine that such research complies with the principles of the statement on the use of human subjects for research of the american association on mental deficiency and with the principles for research involving human subjects required by the United States department of health, education, and welfare for projects supported by that agency.

Section 22. Treatment procedures — restrictions. Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, adversive reinforcement conditioning, or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel, the legal guardian, if any, the responsible person appointed by the court, and any other interested party of the patient's choice. At least one (1) of those consulted must consent to the treatment. If there is no responsible person or if the responsible person appointed by the court is no longer available, then a responsible person who is in no way connected with the facility or with the department of institutions shall be appointed before any such treatment

procedure can be employed. The facility shall send notice of intent to employ extraordinary treatment procedures to the patient, his next of kin, if known, the legal guardian, if any, the attorney who most recently represented him and the responsible person appointed by the court at least ten (10) days prior to the commencement of such extraordinary treatment program.

Section 23. Professional person — qualifications. In every mental health facility to which a person is admitted pursuant to this act:

(1) Each professional person employed by the facility shall meet all licensing and certification requirements promulgated by the state of Montana for persons engaged in private practice of the same profession elsewhere in Montana. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their speciality elsewhere in Montana.

(2) All nonprofessional staff members who have not had prior clinical experience in a mental institution shall have a substantial orientation training.

(3) Staff members on all levels shall have regularly scheduled in-service training.

(4) Each nonprofessional staff member shall be under the direct supervision of a professional person.

Section 24. Treatment plan for patient established.

(1) Each patient admitted to a mental health facility for a period of more than seventy-two (72) hours shall have a comprehensive physical and mental examination and review of behavioral status within forty-eight (48) hours after admission to the mental health facility.

(2) Each patient shall have an individualized treatment plan. This plan shall be developed by appropriate professional persons including a psychiatrist, and implemented as soon as possible, in any event, no later than five (5) days after the patient's admission. Each individualized treatment plan shall contain:

(a) a statement of the nature of the specific problems and specific needs of the patient;

(b) a statement of the least restrictive treatment conditions necessary to achieve the purposes of commitment;

(c) a description of intermediate and long-range treatment goals, with a projected timetable for their attainment;

(d) a statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

(e) a specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these treatment goals;

(f) criteria for release to less restrictive treatment

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conditions, and criteria for discharge;

(g) a notation of any therapeutic tasks and labor to be performed by the patient.

(3) As part of his treatment plan, each patient shall have an individualized after care plan. This plan shall be developed by a professional person as soon as practicable after the patient's admission to the facility.

(4) In the interests of continuity of care, whenever possible, one professional person (who need not have been involved with the development of the treatment plan) shall be responsible for supervising the implementation of the treatment plan, integrating the various aspects of the treatment program and recording the patient's progress. This professional person shall also be responsible for ensuring that the patient is released, where appropriate, into a less restrictive form of treatment.

(5) The treatment plan shall be continuously reviewed by the professional person responsible for supervising the implementation of the plan and shall be modified if necessary. Moreover, at least every ninety (90) days, each patient shall receive a mental examination from, and his treatment plan shall be reviewed by, a professional person other than the professional person responsible for supervising the implementation of the plan.

Section 25. Examination following commitment. No

later than fifteen (15) days after a patient is committed to a mental health facility, the professional person in charge of the facility, or his appointed, professionally qualified agent, shall examine the committed patient and shall determine whether the patient continues to require commitment to the facility and whether a treatment plan complying with this act has been implemented. If the patient no longer requires commitment to the facility in accordance with the standards for commitment, or if a treatment plan has not been implemented, he must be released immediately unless he agrees to continue with treatment on a voluntary basis.

Section 26. Care and treatment following release. The department of institutions and its agents have an affirmative duty to provide adequate transitional treatment and care for all patients released after a period of involuntary confinement. Transitional care and treatment possibilities include, but are not limited to, psychiatric day care, treatment in the home by a visiting therapist, nursing home or extended care, outpatient treatment, and treatment in the psychiatric ward of a general hospital.

Section 27. Treatment of children and young adults. In addition to complying with all the other standards herein, a mental health facility shall make special provisions for the treatment of patients who are children

and young adults. These provisions shall include, but are not limited to:

(a) Opportunities for publicly supported education suitable to the educational needs of the patient. This program of education must, in the opinion of the attending professional person be compatible with the patient's mental condition and his treatment program, and otherwise be in the patient's best interest.

(b) A treatment plan which considers the chronological, maturational, and developmental level of the patient.

(c) Sufficient professional persons, teachers, and staff members with specialized skills in the care and treatment of children and young adults.

(d) Recreation and play opportunities in the open air where possible and appropriate residential facilities, separate, wherever possible, from older patients.

(e) Arrangements for contact between the facility and the family of the patient.

Section 28. Records to be maintained. Complete patient records shall be kept by the mental health facility and shall be available to anyone properly authorized in writing by the patient. These records shall include:

(1) identification data, including the patient's legal status;

(2) a patient history, including, but not limited to:

(a) family data, educational background, and employment record;

(b) prior medical history, both physical and mental, including prior hospitalization;

(3) the chief complaints of the patient and the chief complaints of others regarding the patient.

(4) an evaluation which notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretative, fashion;

(5) a summary of each physical examination which describes the results of the examination;

(6) a copy of the individual treatment plan and any modifications thereto;

(7) a detailed summary of the findings made by the reviewing professional person after each periodic review of the treatment plan which analyzes the successes and failures of the treatment program and directs whatever modifications are necessary;

(8) a copy of the individualized after care plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;

(9) a medication history and status, which includes

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the signed orders of the prescribing physician. The staff person administering the medication shall indicate by signature that orders have been carried out;

(10) a detailed summary of each significant contact by a professional person with the patient;

(11) a detailed summary on at least a weekly basis by a professional person involved in the patient's treatment of the patient's progress along the treatment plan;

(12) a weekly summary of the extent and nature of the patient's work activities and the effect of such activity upon the patient's progress along the treatment plan;

(13) a signed order by a professional person for any restrictions on visitations and communications;

(14) a signed order by a professional person for any physical restraints and isolation;

(15) a detailed summary of any extraordinary incident in the facility involving the patient to be entered by a staff member noting that he has personal knowledge of the incident or specifying his other source of information, and initialed within twenty-four (24) hours by a professional person;

(16) a summary by the professional person in charge of the facility or his appointed agent of his findings after the fifteen (15) day review provided for in section 25.

Section 29. Records to be confidential — exceptions.

All information obtained and records prepared in the course of providing any services under this act to individuals under any provision of this act shall be confidential and privileged matter. Such information and records may be disclosed only:

(1) in communications between qualified professional persons in the provision of services or appropriate referrals;

(2) when the recipient of services designates persons to whom information or records may be released, provided that if a recipient of services is a ward, and his guardian or conservator designates, in writing, persons to whom records or information may be disclosed, such designation shall be valid in lieu of the designation by the recipient; except that nothing in this section shall be construed to compel a physician, psychologist, social worker, nurse, attorney, or other professional person to reveal information which has been given to him in confidence by members of a patient's family;

(3) to the extent necessary to make claims on behalf of a recipient of aid, insurance, or medical assistance to which he may be entitled;

(4) for research, if the department of institutions has promulgated rules for the conduct of research. Such rules shall include, but not be limited to, the requirement

that all researchers must sign an oath of confidentiality;

(5) to the courts, as necessary to the administration of justice;

(6) to persons authorized by an order of court after notice and opportunity for hearing to the person to whom the record or information pertains and the custodian of the record or information pursuant to the rules of civil procedure;

(7) to members of the mental disabilities board of visitors or their agents when necessary to perform their functions as set out in section 30 of this act.

Section 30. Mental disabilities board of visitors — creation and responsibilities. (1) The governor shall appoint a mental disabilities board of visitors. The board shall consist of five (5) persons at least three (3) of whom shall not be professional persons and at lease one (1) of whom shall be a representative of an organization concerned with the care and welfare of the mentally ill. No one may be a member of the board who is an agent or employee of the department of institutions or of any mental health facility affected by this act. If a board of similar title and structure is created in any act concerning the treatment of the mentally retarded or developmentally disabled, then one board shall be created to perform the functions set out in both acts and the board so created shall include at least

one (1) representative of an organization concerned with the care and welfare of the mentally ill and one (1) representative of an organization concerned with the care and welfare of the mentally retarded or developmentally disabled.

(2) The mental disabilities board of visitors shall be an independent board of inquiry and review to assure that the treatment of all persons either voluntarily or involuntarily admitted to a mental facility is humane and decent and meets the requirements set forth in this act.

(3) The board shall review all plans for experimental research involving persons admitted to any mental health facility to assure that the research project is humane and not unduly hazardous and that it complies with the principles of the statement on the use of human subjects for research of the american association on mental deficiency and with the principles for research involving human subjects required by the United States department of health, education, and welfare. No experimental research project involving persons admitted to any mental health facility affected by this act shall be commenced unless it is approved by the mental disabilities board of visitors.

(4) The board shall, at least annually, inspect every mental health facility which is providing treatment and evaluation to any person pursuant to this act. The board

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shall inspect the physical plant, including residential, recreational, dining, and sanitary facilities. It shall visit all wards and treatment areas. The board shall inquire concerning all treatment programs being implemented by the facility.

(5) The board shall annually inspect the treatment file of each person admitted to a mental health facility pursuant to this act to insure that a treatment plan exists and is being implemented. The board shall inquire concerning all use of restraints, isolation, or other extraordinary measures.

(6) The board may assist any patient at a mental health facility in resolving any grievance he may have concerning his commitment or his course of treatment in the facility.

(7) If the board believes that any facility is failing to comply with the provisions of this act in regard to its physical facilities or its treatment of any patient, it shall report its findings at once to the next of kin or guardian of any patient involved, the responsible person appointed by the court for any patient involved, the professional person in charge of the facility, the director of the department of institutions, and the district court which has jurisdiction over the facility.

(8) The mental disabilities board of visitors shall

report annually to the governor and shall report to each session of the Montana legislature concerning the status of the mental health facilities and treatment programs which it has inspected.

(9) The mental disabilities board of visitors shall be attached to the governor for administrative purposes. It may employ staff for the purpose of carrying out its duties as set out in this act.

Section 31. Standards for treatment to be known. Each patient and his next of kin, guardian, conservator, or the responsible person appointed by the court shall promptly upon the patient's admission receive written notice, in language he understands, of all the above standards for adequate treatment. In addition a copy of all the above standards shall be posted in each ward.

Section 32. Section 38-110, R.C.M. 1947, is amended to read as follows:

"38-110. Maintenance of indigent persons on discharge. Upon the discharge of a patient from ~~the state hospital, the department~~ a mental health facility, the professional person in charge of the facility shall notify the ~~board of public welfare~~ welfare department of the county from which the patient was committed. The ~~county board of public welfare~~ county welfare department shall at once ascertain whether the discharged patient is in financial need. If the patient

is found to be in financial need, the ~~county board of public welfare~~ county welfare department shall properly care for and maintain the discharged patient under the ~~Public Welfare Act~~ laws of this state relating to public welfare until the patient is able to care for himself, or until another provision has been made for care of the patient."

Section 33. Section 38-212, R.C.M. 1947, is amended to read as follows:

"38-212. Cost of examination and commitment. The cost of the examination, committal, and taking ~~an insane person to the asylum~~ a person who is seriously mentally ill to a mental health facility must be paid by the county in which he resides at the time he is adjudged ~~insane~~ to be seriously mentally ill. The sheriff must be allowed the actual expenses incurred in taking ~~an insane person~~ a person who is seriously mentally ill to the ~~asylum~~ facility, as provided by section 16-2723 of this code."

Section 34. Section 38-506, R.C.M. 1947, is amended to read as follows:

"38-506. Support of patient ~~placed on convalescent leave, discharged by lapse of time~~ conditionally released. ~~(1)~~ When ~~the state hospital places a patient on convalescent leave,~~ a mental health facility conditionally releases a patient committed to its care, it is not liable for his support while ~~on convalescent leave~~ conditionally released.

Liability devolves upon the legal guardian, parent, or person under whose care the patient is placed on convalescent leave, or upon any other person legally liable for his support. The public welfare officials of the county where the patient resides or is found, are responsible for providing relief and care for ~~the~~ a conditionally released patient ~~on convalescent leave~~ who is unable to maintain himself, or who is unable to secure support from the person under whose care he was placed on convalescent leave, like any other person in need of relief and care, under the public welfare laws. ~~The person under whose care the patient is placed on convalescent leave or any other person legally liable for his support, shall, if the convalescent leave is revoked, be liable for any expense incurred by the state or county in procuring the return of the patient to the hospital.~~

~~(2) The superintendent of the state hospital shall place on convalescent leave any patient under his control when he believes it is in the best interests of the patient and society to do so. If a patient placed on convalescent leave is not returned to the institution within a period of two (2) years, he is considered discharged therefrom and entry shall be made accordingly in the records of the institution. If a patient who has escaped from the institution is not returned thereto within two (2) years, he~~

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~~is considered discharged therefrom and an entry shall be made accordingly in the records of the institution. When a patient is discharged whether by convalescent leave continuing for a period of two (2) years or by having escaped and not having been returned within two (2) years, the superintendent of the state hospital shall immediately notify in writing the judge of the court by which the patient was committed. A person so discharged may not be recommitted to the state hospital except by court order and upon proceedings as required by law for commitment in the first instance. This section does not restore the civil rights of persons so discharged or restore sanity, or relieve the superintendent of the state hospital from the obligation of supervising patients on convalescent leave to the extent of available facilities and finances.~~"

Section 35. Section 38-507, R.C.M. 1947, is amended to read as follows:

"38-507. Clothing for patient on ~~convalescent leave~~ conditional release or discharged patient. A patient ~~or inmate~~ may not be discharged or ~~placed on convalescent leave~~ conditionally released from ~~the state hospital~~ a mental health facility without suitable clothing adapted to the season in which he is discharged."

Section 36. Section 80-1601, R.C.M. 1947, is amended to read as follows:

"80-1601. Institutions subject to per diem charge. The state department of institutions shall collect and process per diem payments for the care of residents in the following institutions and for the care of those persons in foster homes or other facilities for the mentally ill, or the mentally retarded, or developmentally disabled under provisions of the department:

(1) Montana children's center

(2) Warm Springs state hospital

(3) Boulder river school and hospital

(4) Galen state hospital

(5) Montana veterans' home

(6) Montana center for the aged.

(7) Eastmont training center."

Section 37. Severability clause. If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

Section 38. Sections 38-107, 38-108, 38-109, 38-112, 38-113, 38-114, 38-115, 38-116, 38-201, 38-202, 38-203, 38-204, 38-205, 38-206, 38-207, 38-208, 38-208.1, 38-208.2, 38-208.3, 38-209, 38-211, 38-213, 38-401, 38-402, 38-403,

38-404, 38-405, 38-406, 38-406.1, 38-406.2, 38-407, 38-408, 38-408.1, 38-502, 38-503, 38-504, 38-505, and 64-112, R.C.M. 1947, are repealed.

-End-

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44th LEGISLATIVE SESSION

COMMITTEE ON JUDICIARY

SENATE BILL NO.	ENTERED COMM.	DATE CONSIDERED	OUT OF COMM.	DO PASS DATE	DO NOT PASS DATE	DO PASS AS AMEND. DATE	BE CONCURRED IN DATE	BE CONC. IN AS AMENDED DATE	BE NOT CURRED DATE
274	1/29/75	2/18/75	2/24/75			2/24/75			
276	1/27/75	2/5/75	2/5/75	2/5/75					
283	1/27/75	2/11/75	2/18/75			2/18/75			
287	1/27/75	2/6/75	2/6/75		2/6/75				
288	1/27/75	2/6/75	2/6/75		2/6/75				
294	1/29/75	2/4/75	2/4/75			2/4/75			
314	1/30/75	2/13/75	2/21/75			2/20/75			
339	1/31/75	2/7/75	2/10/75			2/8/75			
348	1/31/75	2/12/75	2/12/75			2/12/75			
356	2/1/75	2/11/75	2/21/75			2/21/75			
377	2/6/75	2/19/75	2/24/75			2/22/75			
388	2/7/75	2/19/75	2/24/75			2/22/75			
389	2/7/75	2/17/75	2/24/75			2/22/75			
390	2/10/75	2/21/75	died in committee						
393	2/7/75	2/20/75	2/26/75			2/24/75			
400	2/10/75	2/17/75	2/24/75			2/22/75			
402	2/24/75	2/25/75	2/26/75			2/25/75			

Bills Introduced for Senate, House Bills, and Resolutions

MINUTES OF THE MEETING
JUDICIARY COMMITTEE
February 19, 1975

The meeting was called to order by Senator Towe, Chairman, at 9:43 a.m. in Room 405 of the Capitol Building.

The following bills were discussed:

SB 377
SB 388

Senator Roberts assumed the chair while Senator Towe presented the bills.

SB 377 --- and 388 Senator Towe, District 34, and sponsor of the bills, stated the purpose of the bills is to provide progressive and comprehensive committment procedures for the mentally ill and developmentally disabled. The bills provide for committment procedures including petition, court hearings, and time tables for committment with right of hearing and review. The bills provide for right of hearing and review. The bills provide for right to treatment and procedural rules. Right to counsel cannot be waived; responsible person designation, consent to experimental treatment and therapy, protection of privacy are all vital portions of the bills. An emergency procedure is included in SB 377. A Visitors Board composed of five people appointed by the Governor consisting of 2 professionals and 3 lay persons will be attached to but not under the control of, any department. The board of Visitors will be charged with reviewing the treatment plan for each individual in the institutions and insuring the rights of those individuals.

Pat Melby, representing the Governor's Office, expressed support for the bill, and stated the basic policy of Governor Judge's administration is that the residents of the state's institutions should receive the level of treatment they are legally and morally entitled to and they are afforded the due process of law when they are deprived of their liberty. He cited an example of a six-day old Down's Syndrome baby being committed to Warm Springs as being a flagrant case of denial of rights.

John Delaney, Administrator of Warm Springs State Hospital, stated he agreed with Mr. Melby's remarks and wholeheartedly supports the bill.

Jan Brown, representing the Montana Mental Health Association and the Montana Association of Churches presented her written testimony to the Committee (attached).

Dr. Byrce Hughett, Billings Mental Health Center, stated his support of the bill and noted he had presented some suggested amendments to Senator Towe.

Dan Hahr, Billings Mental Health Center, stated the bills have been thoroughly reviewed by the Mental Health Council and they are in full support. He stated he was very impressed with the section dealing with the rights of patients.

Jerry Lendorf, representing the Montana Medical Association, stated that group's support for H.B. 377.

Tom Honzel, representing the Montana County Attorneys Association, stated current committment procedures are barbaric. In December the Association met with 30 county attorneys present and voted full support for the bills.

Nick Rotering, staff attorney for the Department of Institutions, strongly supported the bills on behalf of the Department. He stated they make good legal and medical sense.

Gregory Jacobs, representing Warm Springs State Hospital, presented his written testimony to the Committee (attached).

Ellen Garrity, representing the Montana Association of University Women, supported the bill as a step forward in the rights of fellow human beings.

Ken Rohyans, representing Region IV Progress, Inc., a regional facility for training adult retarded, spoke in support of the bills citing the need for humane and progressive committment procedures. He presented examples of gross abuse of committment procedures and stated these are not at all unusual.

JoAnn Willis, representing the Montana Association for Retarded Citizens, expressed that group's support for the bill citing the review procedures, right to treatment, and rights of the patients.

Jerry Butcher, acting Superintendent of Boulder River School and Hospital supported the bills and presented his written testimony to the Committee (attached).

Richard Swenson, a psychologist at Boulder River School and Hospital, stated his support of the bill. He requested opportunity of presenting some amendments to the Committee regarding the Boari of Visitors and review of behaviors.

Roger Ogren representing the Coalition for the Rights of the Retarded, stated that group's overwhelming support of the bills and called them exemploary legislation. He also requested an opportunity to discuss some minor amendments.

Gary Pagnatta, representing the Coalition for the Rights of the Retarded, and also an employee of Boulder River School and Hospital, supported the bill with minor amendments.

Pete Berdack, a social worker for Social and Rehabilitation Services asked support for the bill noting there may be some contradictions with the Protective Services Act that should be looked into.

Archie McPhail, psychologist at Warm Springs State Hospital, asked that the definition on page 3 be included in line 11, page 41. He supported the voluntary committment procedure.

Darrell Ophimer, representing the Montana Practical Nurses Association, expressed that group's support of the bills but asked that enabling legislation be considered to provide a training program oriented to the rights of patients. He stated instructors have such a heavy load now that a new program is most necessary.

Ben Alexander, psychiatrist at Warm Springs State Hospital, presented his written testimony to the Committee (attached).

Dr. McCarthy, Warm Springs State Hospital, presented his written testimony to the Committee (attached).

Dr. Camilla Anderson, retired psychiatrist from Sidney stated she agrees with the philosophy of the bill (S.B. 377) but has questions concerning the

grouping under injury and danger, prefers two separate bills -- one for committment and one for treatment, and paranoid orientation. She stated she would like to meet with the sub-committee concerning the bills.

Ray Gulick, a public lobbyist, stated he felt the bills were ambiguous, costly, and don't take into consideration the administrators who must have freedom and money to operate.

Ronald Johnston - Billings, stated he was a victim of the present committment laws, as he was falsely declared insane, falsely arrested, and his family shattered. He is disturbed by the new label "developmentally disturbed" and stated he is writing a book about his experiences. He felt this was an area for God to oversee, not for human dictates. He urged the Committee to oppose the bills.

In closing, Senator Towe related his experiences in researching the bills. He stated he felt the provisions of bills are workable and that community resources should fill in the broad areas outside "injury to one's self or danger to others".

Senator Greely announced a committment bill subcommittee meeting will be held Thursday, Feb. 20, at 11:00 a.m. in Room 442.

There being no further business the meeting adjourned to reconvene Thursday, February 20, at 9:30 a.m.

Thomas E. Towe

Chairman

SENATE JUDICIARY COMMITTEE
Wed. February 19, 1975

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am Jan Brown of Helena, officially representing the Montana Association of Churches. Today I also represent the Mental Health Association of Montana. I speak in support of Senate Bill 377.

The Montana Association of Churches, through a task force on institutions, recently produced a newspaper tabloid, a television film, and sponsored five public forums on mental health care and Montana's institutions. This project was an attempt to make the public more aware of our state institutions and the people who reside in them, as well as to consider the question of what rights these people have and what must be done by government to protect these rights. Rights of the mentally ill is what Senate Bill 377 is all about.

The members of the 11 church bodies who belong to the Montana Association of Churches have a concern with human dignity and human rights. Senate Bill 377 is a long and complex bill and has not been studied by a Montana Association of Churches' task force, so there may be legal or technical problems with the bill that I am unaware of. However, the Montana Association of Churches supports the concept of Senate Bill 377 as set forth in its statement of purpose in Section 1 of the bill.

* * * * *

The Mental Health Association of Montana has actively supported a revised commitment bill during the last two legislative sessions. Senate Bill 377 contains the specific provisions with which the mental health association has been most concerned, namely: the right to a pre-evaluation; rights during pre-commitment proceedings as enumerated in Section 4 of the bill, especially the right to legal counsel; the right to care and treatment in the least restrictive manner available; retention of civil rights if committed unless specifically stated by the court, and restoration upon termination of commitment of any civil or legal rights lost when committed; rights of a person committed to a

mental health facility as enumerated in Section 17 of the bill; provisions for aftercare following a patient's release; and the formation of an independent review board to periodically inspect mental health facilities and review programs and patient treatment plans.

In addition to protecting the rights of the mentally ill, Senate Bill 377 includes provisions for preserving the rights of the members of society to be protected from mentally ill persons who may be dangerous to others.

The Mental Health Association of Montana urges your support of Senate Bill 377.

Thank you.

COMMENTS AND SUGGESTIONS FOR AMENDMENTS ON SENATE BILL 377 - "AN ACT TO PROVIDE FOR DETERMINATION AND TREATMENT OF THE SERIOUSLY MENTALLY ILL AND THOSE SUFFERING FROM MENTAL DISORDERS"

I. INTRODUCTION

For many years, Montana has needed a revision of the law providing for the commitment of the seriously mentally ill(involuntary). It is first of all necessary to recognize that there is a wide variety of types of mental illness, and it is necessary in the laws to separate those types of mental illness in which the patient may, because of their illness, fail to recognize their need for treatment and require an involuntary type of commitment to treatment, from those who recognize their illness and will voluntarily seek treatment. We have needed a law guaranteeing the civil rights of patients, and their treatment rights. Further, it is important that we recognize the present status of treatment resources in the State of Montana in proposing a new law, while at the same time providing some impetus for the development of better resources for treatment. In writing such a law, it is important to recognize the experience of California and other states, who have, in the interest of protecting the patients' civil rights, pushed them out of treatment facilities into communities which were unable to provide for their treatment, with the result that the patients are now much worse off than they were before. There is some parallel for the possibility of the same experience happening in Montana. The Community Comprehensive Mental Health Centers in Great Falls and in Butte have just been funded in recent months and are in a state of development. The Miles City Community Comprehensive Mental Health area has had continual staffing problems throughout its history. The Community Comprehensive Mental Health Centers in Billings and in Missoula seem to be in a far better position to assume these added responsibilities than the others, although the two, as we understand it, are suffering with some staffing problems. This is

particularly true of the lack of in-patient hospital facilities presently available to psychiatric patients in need of hospitalized services.

II. RECOMMENDATIONS FOR POSSIBLE AMENDMENTS TO THE BILL AS SUBMITTED

Relating to the definition of professional person on Page 3, Line 9 and comparing it with Section 23, Page 41, Line 8, there is conflict in that they do not both set the same requirements. It would be a recommended change that on Page 3, the definition be changed to: 1) A medical doctor with some experience and knowledge in the field of mental illness. 2) A psychologist with a doctoral or master's degree from an accredited program and with specialized training, or one year's experience in treating the mentally ill. 3) A social worker with a master's degree from an accredited program and with specialized training, or one year's experience in working with the mentally ill. 4) A registered nurse with specialized training, or one year's experience in treating the mentally ill under the supervision of a qualified mental illness professional, and the reference in Section 23 be eliminated.

Referring to Section 3, Page 4, Line 16: The idea of voluntary "commitment" should be eliminated from any consideration in regard to mental health. "Commitment" should be changed to the word "admission", or "admission for treatment." The existing voluntary admission law in the statutes, which is 38-408.1, should be allowed to remain in the law, and amended to provide that at any time during a patient's hospitalization for treatment they may request their release and further action as outlined in the present voluntary admission law should be taken within five (5) days. The mentally ill or mentally disturbed person should have the right to seek treatment wherever the required treatment is available.

The provisions for the various types of hearings should be reviewed with the idea in mind of considering the practicality of the various hearings and

whether or not all of these hearings are necessary. One of the prime considerations needs to be the availability throughout the state of professional persons who can handle such provisions.

In comment on the Section 30, regarding the mental disabilities board of visitors, we find no exception with the majority part of this Bill. However, in Paragraph 5, on Page 51, Line 6, it states that the board "shall annually inspect the treatment file of each person admitted to a mental health facility . . ." We raise the question of whether or not the board's having access to the treatment file would breach the confidentiality aspect of the information given by the patient to a professional person.

In reference to Section 32, on Page 52, which amends Section 38-110 of a present law regarding maintenance of indigent persons on discharge; it is important to point out that the provision of assistance has been moved from the responsibility of the Welfare Department to the Social Security Administration under laws providing for supplementary security income provisions.

Gregory M. Jacobs, A.C.S.W.
Director, Social Service Department
Warm Springs State Hospital

John R. Rosenleaf, M.S.W.
Assistant Director, Social Service
Department, Warm Springs State Hospital

GMJ-JRR/HB

COMMENTS&SUGGESTIONS on Senate Bil-377-by an Opponent of Bill as so constituted
A Proponent of Mental treatment proposals,which will aid.

Difficulties can be foreseen if Voluntary patients are turned away from WSSH ,
the largest treatment center,extent in Montana,for care&Rx of the mentally ill.
May not retain 38-98.1-(Provision for voluntary committment)

The bill has the ring of a Hospital procedures manual (everything included
in the proposal,but the kitchen sink)& yet in actual Reality of Hospital
procedure,we are following proposals,QUITE similar.

So recommend considerations of Voluntary "Admissions"as separate from "INvolun-
tary commitment.In fact,if a voluntary Admission had to travel to the regional
center before being Hospitalized,he might come to harm.
It is important to recognize the expereinces in other States where patients have
been pushed outinto the community before treatment could be provided in such
communities.
There is a conflict expressed in Bill 377,regards provisions for voluntary
Admsissions-Conflict noted between procedure noted PP4 Sect.3,line17&Pp5
procedure,in sect.3 line12-14. Begins Sect.3"NOTHING in this act etc"

On Pp44Sect.27,line22-Procedures are set-out which to all purposes eliminate
the admission of children,as WSSH would have difficulty meeting requirements.

As to the "Progfesional Person" matter, that could be anyone.In practice,
the care&screening of mental problem cases,has been done to advantage,(especially
re; crisis& admissions) by Psychiatrists.The State Of Montana does Employ them
so might as well make us of them!
Appointing the "Responsible person" can bring much grief.Why not avail our-
selves of as much aid from the courts as is needed-rather than inserting
"responsible person"into picture.
Provisions for various types of reviews& hearings might be considered with a
view towards expense&practicality of all.Is the Montana community apparatus
able to cop-e with all these needs.?
Most existing facilities in Montana are not equiped to detain persons or to
care for them in in-pt. setting, only day-care at best.
Restraints& medications should be considered from the therapeutic aspect at
all times- & there are Therapeutic indications for same.
Mental Health professionals should be trusted by Administration&not just be
lectured&led to unessesary work.Say onPp52 sect.31,lines14-15-Posting of
standards of Rx,on the wards, is inviting a hassel from patients- a waste
of professional time.
Why do we need a board?Why not propose a State Commission for Mental Health
composed of the MOST capable of professionals,to oversee management of Programs
which are going to be quite expensive.Who ever comes about,inspection of pt.
records could breach pt. confidentiality.
Who would pay for the after care of indigent persons? In fact,provisions for
financial aid etc. are often NOT piked up by the Welfare Dept. but
by Social security
When dealing with minors, responsibilites& authority of the parents must be
observed- a "responsible person" should not be appointed,when blood kin,will
take such responsibility.
Other suggestions- too numerous to mention

D.E.McCarthy M.D.
Psychiatrist

SB 377 -- Senator Greely moved to amend page 3, lines 10-14 (See attached Committee Report) and to amend HB 388 in a like manner; to amend page 37, lines 17 through 19; and to adopt the amendments as presented by the sub-committee and Committee Reaearcher. THE MOTION CARRIED UNANIMOUSLY ON A ROLL CALL VOTE.

Senator Greely moved SB 377 as amended do pass. THE MOTION CARRIED UNANIMOUSLY ON A ROLL CALL VOTE.

SB 388 -- Senator Greely moved to accept the amendments proposed by the Committee Researcher and subcommittee. THE MOTION CARRIED UNANIMOUSLY ON A ROLL CALL VOTE WITH SENATORS ROBERTS AND BROWN ABSENT.

Senator Drake moved SB 388 do pass as amended. THE MOTION CARRIED UNANIMOUSLY ON A ROLL CALL VOTE WITH SENATORS BROWN AND ROBERTS ABSENT.

SJR 22 -- Senator Greely moved SJR 22 do pass. THE MOTION CARRIED UNANIMOUSLY ON A ROLL CALL VOTE WITH SENATORS ROBERTS AND BROWN ABSENT.

SB 153 -- Senator Greely moved to adopt the amendments proposed by the Committee Researcher and subcommittee. THE MOTION CARRIED UNANIMOUSLY ON A ROLL CALL VOTE WITH SENATORS ROBERTS AND BROWN ABSENT.

Senator Turnage moved SB 153 do pass as amended. THE MOTION CARRIED UNANIMOUSLY ON A ROLL CALL VOTE WITH SENATORS ROBERTS AND BROWN ABSENT.

There being no further business, the meeting adjourned to reconvene February 24, at 9:30 A.M.

Thomas E. Towe, Chairman

STANDING COMMITTEE REPORT

February 24 19 75

MR. PRESIDENT

We, your committee on JUDICIARY

having had under consideration SENATE Bill No. 377

Respectfully report as follows: That SENATE Bill No. 377

introduced bill, be amended as follows:

1. Amend title, page 1, line 7.
   Following: "38-507"
   Strike: "80-1601"
   Insert: "80-2501"

2. Amend page 3, Section 2, lines 10 through 14.
   Following: "by the"
   Strike: lines 10 through 14 in their entirety
   Insert: "department of institutions in accordance with standards of professional licensing boards, federal regulations, and the joint commission on accreditation of hospitals."

3. Amend page 4, Section 3, line 16.
   Following: "Voluntary"
   Strike: "commitment"
   Insert: "admission"

DO PASS CONTINUED

Chairman.

STATE PUB. CO.
Helena, Mont.

4. Amend page 4, Section 3, line 16.
   Following: "of"
   Strike: "commitment"
   Insert: "admission"

5. Amend page 4, Section 3, line 19.
   Following: "for"
   Strike: "commitment"
   Insert: "admission"

6. Amend page 4, Section 3, line 25.
   Following: "voluntarily"
   Strike: "committing"
   Insert: "admitting"

7. Amend page 5, Section 3, line 2.
   Strike: "committing himself"
   Insert: "applying for admission"

8. Amend page 5, Section 3, line 4.
   Following: "Any"
   Strike: "person"
   Insert: "applicant"

9. Amend page 5, Section 3, lines 4 and 5.
   Following: "voluntarily"
   Strike: "commit himself"
   Insert: "apply for admission"

10. Amend page 5, Section 3, line 7.
    Following: "or"
    Insert: "if not reasonably available, from"

11. Amend page 5, Section 3, lines 7 and 8.
    Following: "person"
    Strike: "designated by the regional director"

12. Amend page 5, Section 3, line 8.
    Following: "that the"
    Strike: "person"
    Insert: "applicant"

13. Amend page 5, Section 3, line 10.
    Following: "region"
    Insert: "in which the applicant resides"

14. Amend page 5, Section 3, line 12.
    Following: "voluntary"
    Strike: "commitment"
    Insert: "admission"

15. Amend page 5, Section 3, line 15.
    Following: "voluntarily"
    Strike: "committed"
    Insert: "admitted"

16. Amend page 5, Section 3, line 11.
Following: "residence"
Insert: "at the time of admission"

17. Amend page 6, Section 3, line 5.
Following: line 5
Insert: "(8) Voluntary commitment of a minor to a mental health facility for an in-patient course of treatment shall be for a period of no more than thirty (30) days. If the professional person in charge of a minor patient determines that the commitment should continue for a period of more than thirty (30) days, he shall commence involuntary commitment proceedings in accordance with this act. Counsel shall be appointed for the minor.
(9) If, in any voluntary commitment for any period of time to a mental health facility, a minor fails to join in the consent of his parents or guardian to the voluntary commitment, then the commitment shall be treated as an involuntary commitment. Notice of the substance of this subsection and of the right to counsel shall be set forth in conspicuous type in a conspicuous location on any form or application used for the voluntary commitment of a minor to a mental health facility. The notice shall be explained to the minor by the professional person approving the application."

18. Amend page 6, Section 4, line 16.
Following: "been"
Strike: "committed"
Insert: "detained"

19. Amend page 6, Section 4, line 21.
Following: "court."
Insert: "The right of the respondent to be physically present at a hearing may also be waived by his attorney and the responsible person with the concurrence of the professional person and the judge upon a finding supported by facts that:
(a) the presence of the respondent at the hearing would be likely to seriously adversly affect his mental condition, and
(b) an alternative location for the hearing in surroundings familiar to the respondent would not prevent such adverse affects on his mental condition."

20. Amend page 7, Section 4, line 7.
Following: "is"
Strike: "a"
Insert: "an apparent"

21. Amend page 11, Section 5, line 8.
Following: "or"
Strike: "commitment"
Insert: "admission"

22. Amend page 13, Section 5, line 9.
Following: "or"
Strike: "commitment"
Insert: "admission"

23. Amend page 14, Section 6, line 7.
Following: "retain"
Insert: "the patient in"

24. Amend page 14, Section 6, line 7.
Following: "custody"
Strike: "of the patient"
Insert: "by court order"

25. Amend page 14, Section 6, line 9.
Following: "injury to"
Strike: "himself"
Insert: "the patient"

26. Amend page 15, Section 6, line 21.
Following: "doubt."
Insert: "Any court may order a hearing closed to the public for the protection of the respondent."

27. Amend page 16, Section 6, line 20.
Following: "suitable."
Insert: "The court shall enter into the record a detailed statement of the facts upon which it found the respondent to be seriously mentally ill."

28. Amend page 17, Section 6, line 1.
Following: "patient"
Strike: "will"
Insert: "shall"

29. Amend page 18, Section 6, lines 2 and 3.
Following: "commitment"
Strike: "save and"

30. Amend page 18, Section 6, line 7.
Following: "patient"
Strike: "to be"

31. Amend page 18, Section 6, line 10.
Following: "from"
Strike: "such"

32. Amend page 20, Section 7, line 20.
Following: "safety"
Insert: "or the life or safety of the respondent"

33. Amend page 23, Section 8, lines 1 through 6.
Following: "and"
Strike: lines 1 through 6 in their entirety
Insert: "returned to the facility from which he was"

34. Amend page 23, Section 8, line 9.
Following: " time"
Strike: line 9 in its entirety
Insert: "."

35. Amend page 23, Section 8, lines 10 through 14.
Strike: lines 10 through 14 in their entirety

36. Amend page 23, Section 8, line 15.
Strike: "court and"
Insert: "The professional person shall"

37. Amend page 23, Section 8, lines 18 through 25, through line 16 on page 24.
Following: "court."
Strike: lines 18 through 25, through line 16 on page 24 in their entirety.

38. Amend page 24, Section 8, lines 22 through 25.
Following: "person"
Strike: lines 22 through 25 in their entirety
Insert: "."

39. Amend page 25, Section 8, line 2.
Following: "the"
Strike: "person"
Insert: "patient"

40. Amend page 25, Section 8, line 3.
Following: "committed the"
Strike: "person"
Insert: "patient"

41. Amend page 25, Section 8, line 4.
Following: "provided"
Insert: "by the professional person in charge of the patient"

42. Amend page 25, Section 9, line 7.
Following: "shall"
Insert: "have the right to"

43. Amend page 25, Section 9, line 16.
Following: "the"
Strike: "arrest"
Insert: "detention"

Amend page 25, Section 9, line 17.
Following: "custody"
Insert: "of the respondent"

45. Amend page 26, Section 9, line 6.
Following: "examination"
Insert: "who will be compensated from the public funds of the county where the respondent resides"

46. Amend page 26, Section 9, line 19.
Strike: "until and"

47. Amend page 26, Section 9, line 19.
Following: "orders"
Strike: "hem"
Insert: "the record"

48. Amend page 27, Section 11, line 4.
Follwoing: "short-term"
Insert: "evaluation and"

49. Amend page 27, Section 11, lines 4 and 5.
Following: "long-term"
Strike: "care and treatment"
Insert: "commitment"

50. Amend page 33, Section 17, line 19.
Following: "of"
Insert: "contrary"

51. Amend page 37, Section 18, line 17.
Following: "(5)"
Strike: "patients shall be allowed to use"
Insert: "deductions or payments for care and other charges shall not deprive a patient of"

52. Amend page 37, Section 19, lines 23 and 24.
Following: "physician."
Strike: "The professional person in charge of the facility and the"
Insert: "The"

53. Amend page 38, Section 19, line 6.
Following: "care."
Strike: "All"
Insert: "Except in the case of out-patients, all"

54. Amend page 38, Section 19, line 9.
Following: "a substitute for"
Insert: "a treatment"

55. Amend page 40, Section 22, line 14.
Following: "lobotomy,"
Strike: "electro-convulsive treatment,"

56. Amend page 41, Section 23, line 11.
Following: "person"
Insert: "and other staff member"

57. Amend page 41, Section 23, line 12.
Following: "all"
Strike: "licensing and"

58. Amend page 41, Section 23, lines 13 through 15.
Following: "the"
Strike: "State of Montana for persons engaged in private practice of the same profession elsewhere in Montana"
Insert: "Department of Institutions"

59. Amend page 41, Section 23, lines 15 through 17.
Following: "Montana."
Strike: lines 15 through 17 in their entirety.

60. Amend page 42, Section 24, line 1.
Following: "admitted"
Insert: "as an inpatient"

61. Amend page 42, Section 24, line 5.
Following: "psychiatrist,"
Insert: "if reasonably available"

62. Amend page 44, Section 26, line 20.
Following: "care,"
Insert: "a half-way house,"

63. Amend page 45, Section 28, line 22.
Following: "to"
Strike: "anyone properly"
Insert: "any professional person or attorney"

64. Amend page 45, Section 28, line 23.
Following: "patient"
Insert: "and the board"

65. Amend page 51, Section 30, lines 6 through 8.
Following: "annually"
Strike: "inspect the treatment file of each person admitted to a mental health facility pursuant to this act" to"

66. Amend page 51, Section 30, line 9.
Following: "implemented"
Insert: "for each patient admitted or committed to a mental health facility under this act"

67. Amend page 52, Section 32, line 19.
Strike: "Upon"
Insert: "Prior to"

68. Amend 54, Section 34, lines 2 and 3.
Following: "placed"
Strike: "on convalescent leave"
Insert: "when conditionally released"

69. Amend page 55, Section 36, line 24, through 25, through line 14 on page 56
Following: "Section 36."
Strike: Lines 24 through 25, through line 14 on page 56
Insert: "Section 80-2501, R.C.M. 1947, is amended to read as follows:

"80-2501. Location and function of center. The institution located at Lewistown is the "Montana Center for the Aged." The primary function of the center is the care and treatment of senile persons who have been admitted to Warm Springs state hospital and subsequently transferred to the center. As used ~~in this chapter "senility" means mental illness resulting from the aging process.~~"

Renumber: Subsequent sections

AND AS SO AMENDED, DO PASS

Thomas E. Towe
Chairman

3

JUDICIARY COMMITTEE

44th Legislature

Subject Matter	Date In	Sponsor	Hearing Date	Committee Action	Date Co
Authorizing the creation of community-based centers for rehabilitating criminal offenders.	3/4/75	Towe	3/18/75	AS SO AMENDED BE CONCURRED IN	3/21/75
To provide for determination & treatment of seriously mentally ill & those suffering from mental disorders.	3/4/75	Towe	3/15/75	3/19 Sec rule referred BE CONCURRED IN	3/21/75
To provide for the identification, habilitation & human rights of the developmentally disabled.	3/4/75	Towe	3/15/75	BE CONCURRED IN	3/21/75
To change the consumer counsel committee into a committee for the protection of citizen's rights; expanding membership, responsibilities & authorizing, etc.	3/4/75	Towe	3/10/75	AS SO AMENDED BE CHOT CONCURRED IN	3/14/75
"The judicial office campaign finance act" to provide a method of public financing of judicial campaigns; increasing attorneys' license tax, etc.	3/4/75	Roberts	3/8/75	AS SO AMENDED BE CONCURRED IN	3/17/75
To remove requirement for a primary election for judicial officers when the number of candidates contesting in primary is same, etc.	3/4/75	Lynch	3/7/75	BE NOT CONCURRED IN	3/10/75

JUDICIARY COMMITTEE

March 15, 1975

The sixty seventh meeting of the House Judiciary Committee was called to order in Room 436 of the Capitol Building at Helena, Montana on Saturday, March 15, 1975 at 9:05 AM. Representative Herb Huennekens, Chairman, presided. All members were present except Representatives Moore, Kimble, Maloy, Scully and Vincent, absent, excused.

Bills scheduled for hearing this date were Senate Bills No. 112, 377, 388 and 221, and were heard in this order.

SENATE BILL NO. 112 Senator John W. Devine, District #19, is chief sponsor of the bill. Representative Dennis Lester, taking the place and testifying for Senator Devine, stated this is a simple bill raising the requirement of financial responsibility. It is similar to his bill except that it raises the limits even higher.

No proponents. No opponents. No closing. Following brief discussion of limits as insurance is written now, during which Boyce Clark stated they wouldn't write anything for less than 25, 50 now, the hearing was closed.

SENATE BILLS NOS. 377 & 388 Senator Thomas Towe, District #34, chief sponsor, requested that these bills be heard simultaneously.

Chairman Huennekens imposed a time limit of forty minutes to each side and if there is unused time will allow additional testimony.

Senator Towe stated these are the commitment procedures bills; SB 388 relates to the mentally retarded commitment to Boulder, SB 377 relates to commitment procedures at Warm Springs. Each bill: 1) Reforms process for commitment, updates and revises rights of those committed; 2) Guarantees the right of treatment and rights of individual; 3) Sets up a board of visitors who will have an opportunity to review to be sure everyone is being treated fairly.

In the definition on page 4 of SB 377 the most important sentence is "no person may be admitted because he is" (and these are listed under 1, 2 and 3.) Mere senility is not cause to have someone committed to Warm Springs. The state has an obligation to these people.

The definition on page 5 of SB 388 of a person mentally retarded which is "developmentally disabled" in other words means he cannot get along in some other facility. The definitions are changed, are more restrictive and will be more beneficial.

The bills provide for a four hour commitment procedure which goes through the county attorney, a petition, doctors, an examination and these are the first steps. An individual can be detained for seventy two hours. If seriously ill he can get a three month commitment. Bill calls for renewal every year, no open ended commitment. There must be an attorney, a waiver and hearing must be held before a three month commitment. The bills provide for a large number of rights that are guaranteed. On page 9 in SB 377 the "right that an individual has to have professional person of his own choosing" is included. On page 5 of SB 388 the rights are similar. If a person commits himself he must be released on request after five days.

Senator Towe stated that these bills have been worked out with county attorneys, the judiciary, psychiatrists and are supported generally by all organizations that he is aware of.

Part II of the bill provides the right of treatment and a treatment plan is required for every person. The bills include a provision for confidentiality.

Proponent Pat Melby, a staff attorney in the Governor's office, stated the basic philosophy is residents of state institutions should receive level of care they are entitled to by the constitution. He cited examples of why these bills are needed.

Proponent John Delaney, administrator at Warm Springs, spoke in favor of SB 377 and stated it does all the things Senator Towe and Pat Melby have discussed. It repeals all of current statutes in existence, present ones are archaic and barbaric.

Proponent Jerry Loendorf, representing the Montana Medical Association, supported the bills (see prepared statement). Jan Brown, representing the Montana Mental Health Association and the Association of Churches, stated they support the concepts of these bills and left prepared statements.

Proponent Tom Honzel, representing the Montana County Attorneys Association, stated present laws are archaic and barbaric, a number of counties have developed their own procedures. These procedures are somewhat similar to what is in these bills. The bills do protect individuals' rights quite adequately.

Proponent Eugene Huntington, representing Nick Rotering and the Department of Institutions, stated they support this bill and they have had input into the bill. Proponent Dr. Wm. Alexander, M.D., a psychiatrist at Warm Springs State Hospital, stated the bill is long overdue and they should help a great deal. He is worried about the seventy two hour evaluation because have only five community mental health centers in the state and they are not well staffed.

Proponent Jerry Butcher, acting superintendent at Boulder River School and Hospital, stated he hopes this bill will be passed.

Other proponents in support of these bills were Dr. Richard Swensen from BRS&H, Roger Ogrin, representing a coalition, Joan Willis, representing people who are citizens, and Rosemary Zion, representing herself. Ms. Zion stated she had drafted these bills and wishes to verify what Senator Towe had said in his testimony.

Opponent Ray Gulick from Joplin, Montana stated he would like to bring up the subject of when you are declared incompetent. Feels it should be taken into consideration that perhaps the family is pushing for commitment for devious reasons.

Opponent Dr. Camille Anderson who stated she was an old line psychiatrist from Sidney, Montana, opposed the bill in great detail and length (see prepared testimony).

No other opponents. Senator Towe, in closing, stated he had spent a great deal of time visiting with Dr. Anderson and that they have a basic difference in philosophy. He stated this bill addresses itself to those persons we want to push into Warm Springs. He also elaborated on the seventy two hour treatment which is guaranteed in all cities.

Questions from committee members centered around the seventy two hour procedure. Much concern was expressed regarding available facilities in certain portions of the state and Senator Towe reassured committee members by explaining the procedures as enlisted in the bill that this wouldn't be such a cumbersome problem.

Hearing on this bill was closed at 10:45 AM.

SENATE BILL NO. 221 The committee did not have a quorum at the begining of this hearing but it was understood with Senator Drake and those from out of town who wish to testify that another hearing would be held at a later date. Ultimately, a quorum was present and this was considered the hearing on the bill.

Senator Glenn L. Drake, District #16, is chief sponsor of this no-fault proposal. He stated there are amendments which are being proposed to the bill. The problem is in paying for it and how do you get this benefit without drastically increasing cost. SB 221 addresses the problem differently than the "mandatory threshold" approach and one way is by reducing judgement by amount the person has received in benefits. Bill prohibits double recovery. The amendment on the bottom of page 1 limiting tort actions addresses principal problem on the theory it is cheaper for an insurance company to pay something than try to defend the case.

Mental Health Association of Montana, Inc.

A DIVISION OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.
201 South Last Chance Gulch · Helena, Montana 59601 · (406) 442-4276

March 15, 1975

IDENT
N BROWN
S Peete
ena, MT 59601
IDENT-ELECT
RLES AVERILL
ox 3
rman, MT 59452
PRESIDENT
A VanARSDALE
5 Montana Lane
ings, MT 59101
ETARY
VERNA McFADDEN
rmen, MT 59639
ASURER
R. HARLAN RIGGS
1 North Ave. East
issoula, MT 59801
CUTIVE COMMITTEE
LY ASHTON
41 Hilltop Drive
ena, MT 59601
T BROWN
ox 1, Box 406
rman, MT 59718
ACE LEUTHOLD
en, MT 59857
ROSE LOENDORF
01 Jerome Place
ena, MT 59601
HEL WARWICK
ox 1553
ls, MT 59201
RD OF DIRECTORS
RNA BALL
ley, MT
L JOHN BROOS
ings, MT
EK CHARLSON
ex, MT
VAY BARICK
ield, MT
HOTHY HELLANDER
rmen, MT
LTER HUFFMAN
Thurber, MT
RIS B. JOHNSON
ex, MT
ANA McCORKLE
ssoula, MT
ELYN NICOLAISEN
ma, MT
M ROGETTE
rmen, MT
YLAN SNYDER
ywood, MT
V. RICHARD SUTTERLIN
ngston, MT
ED Director to NAMH
OTHY HELLANDER
rmen, MT
Representative, Region I
YN SNYDER
ywood, MT
Secretary
RIS GOETTEL
S. Last Chance Gulch
ena, MT 59601

TO THE HOUSE JUDICIARY COMMITTEE:

As President of the Mental Health Association of Montana, I express the support of the Association for Senate Bill 377.

Our Association has actively supported a revised commitment bill during the last two legislative sessions. Senate Bill 377 has been reworked from the previous bills with the help of lawyers, judges, psychiatrists and other mental health professionals.

This bill contains the specific provisions with which the Mental Health Association has been most concerned, including pre-evaluation; right to counsel during pre-commitment proceedings; right to care and treatment in the least restrictive manner available; retention of civil rights if committed unless specifically stated by the court, and restoration upon termination of commitment of any civil or legal rights lost when committed; aftercare; and an independent review board.

In addition to protecting the rights of the mentally ill, Senate Bill 377 includes provisions for preserving the rights of the members of society to be protected from mentally ill persons who may be dangerous to others.

The Mental Health Association of Montana urges your support of Senate Bill 377.

Thank you.

Sincerely,

Jean Brown

Jean Brown
PRESIDENT

Montana Association of Churches

WORKING TOGETHER:

- American Baptist Churches of the Northwest
- American Lutheran Church Rocky Mountain District
- Christian Church (Disciples of Christ) in Montana
- Episcopal Church Diocese of Montana
- Lutheran Church in America Pacific Northwest Synod
- Roman Catholic Diocese of Great Falls
- Roman Catholic Diocese of Helena
- United Church of Christ Montana Conference
- United Presbyterian Church Glacier Presbytery
- United Methodist Church Yellowstone Conference
- United Presbyterian Church Yellowstone Presbytery

ROCKY MOUNTAIN COLLEGE
Kimball Hall

1511 Poly Drive
Billings, Montana 59102

MONTANA RELIGIOUS LEGISLATIVE COALITION

Box 404
Helena, Montana 59601

March 15, 1975

TO THE HOUSE JUDICIARY COMMITTEE :

As the legislative liaison for the Montana Association of Churches, I urge your support of Senate Bills 377 and 388.

The Montana Association of Churches, representing eleven church bodies in our state, has not had a task force studying these two bills and, therefore, has not officially voted to support them.

However, the Montana Association of Churches has had a task force studying Montana's institutions and has carried out an extensive public education campaign entitled "Us and Them," regarding our institutions. M.A.C. is also concerned with human rights and the dignity of all persons, which Senate Bills 377 and 388 help to protect.

I therefore express the Montana Association of Churches' support of the concepts embodied in Senate Bills 377 and 388.

Thank you for your favorable consideration of these bills.

Sincerely,

Jan Brown

Jan Brown
LEGISLATIVE LIAISON

STATE OF MONTANA

Office of the Governor

Budget and Program Planning

Capitol Building · Helena, Montana 59601

Thomas L. Judge
Governor

Keith L. Colbo
Director

September 26, 1974

MEMORANDUM

TO: Michael G. Billings, Director

FROM: Pat Melby, Staff Attorney PEM

SUBJECT: Standards for Institutions for the Mentally Handicapped

Attached is a copy of the court ordered standards from the case of Wyatt v. Stickney.

The standards for Bryce and Searcy Hospitals (Alabama's institutions for the mentally ill) are found at 344 F. Supp. 373 and the standards for Partlow State School and Hospital (Alabama's institution for the mentally retarded) are found at 344 F. Supp. 387.

I would suppose that similar standards would be imposed on Warm Springs State Hospital and Boulder River School and Hospital by federal courts if right to treatment suits were brought against those institutions.

PEM/cd

COURT-ORDERED STANDARDS FOR BRYCE AND SEARCY HOSPITALS

I. DEFINITIONS:

a. "Hospital" – Bryce and Searcy Hospitals.

b. "Patients" – all persons who are now confined and all persons who may in the future be confined at Bryce and Searcy Hospitals pursuant to an involuntary civil commitment procedure.

c. "Qualified Mental Health Professional" –

(1) a psychiatrist with three years of residency training in psychiatry;

(2) a psychologist with a doctoral degree from an accredited program;

(3) a social worker with a master's degree from an accredited program and two years of clinical experience under the supervision of a Qualified Mental Health Professional;

(4) a registered nurse with a graduate degree in psychiatric nursing and two years of clinical experience under the supervision of a Qualified Mental Health Professional.

d. "Non-Professional Staff Member" – an employee of the hospital, other than a Qualified Mental Health Professional, whose duties require contact with or supervision of patients.

II. HUMANE PSYCHOLOGICAL AND PHYSICAL ENVIRONMENT

1. Patients have a right to privacy and dignity.

2. Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment.

3. No person shall be deemed incompetent to manage his affairs, to contract, to hold professional or occupational or vehicle operator's licenses, to marry and obtain a divorce, to register and vote, or to make a will *solely* by reason of his admission or commitment to the hospital.

4. Patients shall have the same rights to visitation and telephone communications as patients at other public hospitals, except to the extent that the Qualified Mental Health Professional responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued. Patients shall have an unrestricted right to visitation with attorneys and with private physicians and other health professionals.

5. Patients shall have an unrestricted right to send sealed mail. Patients shall have an unrestricted right to receive sealed mail from their attorneys, private physicians, and other mental health professionals, from courts, and government officials. Patients shall have a right to receive sealed mail from others, except to the extent that the Qualified Mental Health Professional responsible

for formulation of a particular patient's treatment plan writes an order imposing special restrictions on receipt of sealed mail. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued.

6. Patients have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. The superintendent of the hospital and the attending physician shall be responsible for all medication given or administered to a patient. The use of medication shall not exceed standards of use that are advocated by the United States Food and Drug Administration. Notation of each individual's medication shall be kept in his medical records. At least weekly the attending physician shall review the drug regimen of each patient under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the patient's treatment program.

7. Patients have a right to be free from physical restraint and isolation. Except for emergency situations, in which it is likely that patients could harm themselves or others and in which less restrictive means of restraint are not feasible, patients may be physically restrained or placed in isolation only on a Qualified Mental Health Professional's written order which explains the rationale for such action. The written order may be entered only after the Qualified Mental Health Professional has personally seen the patient concerned and evaluated whatever episode or situation is said to call for restraint or isolation. Emergency use of restraints or isolation shall be for no more than one hour, by which time a Qualified Mental Health Professional shall have been consulted and shall have entered an appropriate order in writing. Such written order shall be effective for no more than 24 hours and must be renewed if restraint and isolation are to be continued. While in restraint or isolation the patient must be seen by qualified ward personnel who will chart the patient's physical condition (if it is compromised) and psychiatric condition every hour. The patient must have bathroom privileges every hour and must be bathed every 12 hours.

8. Patients shall have a right not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.

9. Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, adversive reinforcement conditioning or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel or interested party of the patient's choice.

10. Patients have a right to receive prompt and adequate medical treatment for any physical ailments.

11. Patients have a right to wear their own clothes and to keep and use their own personal possessions except insofar as such clothes or personal possessions may be determined by a Qualified Mental Health Professional to be dangerous or otherwise inappropriate to the treatment regimen.

12. The hospital has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable clothing of their own. Patients shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the patient's throughout his stay in the hospital.

13. The hospital shall make provision for the laundering of patient clothing.

14. Patients have a right to regular physical exercise several times a week. Moreover, it shall be the duty of the hospital to provide facilities and equipment for such exercise.

15. Patients have a right to be outdoors at regular and frequent intervals, in the absence of medical considerations.

16. The right to religious worship shall be accorded to each patient who desires such opportunities. Provisions for such worship shall be made available to all patients on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.

17. The institution shall provide, with adequate supervision, suitable opportunities for the patient's interaction with members of the opposite sex.

18. The following rules shall govern patient labor:

A. Hospital Maintenance No patient shall be required to perform labor which involves the operation and maintenance of the hospital or for which the hospital is under contract with an outside organization. Privileges or release from the hospital shall not be conditioned upon the performance of labor covered by this provision. Patients may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. Sec. 206 as amended, 1966.

B. Therapeutic Tasks and Therapeutic Labor

(1) Patients may be required to perform therapeutic tasks which do not involve the operation and maintenance of the hospital, provided the specific task or any change in assignment is:

a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and

b. Supervised by a staff member to oversee the therapeutic aspects of the activity.

(2) Patients may voluntarily engage in therapeutic labor for which the hospital would otherwise have to pay an employee, provided the specific labor or any change in labor assignment is:

a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and

b. Supervised by a staff member to oversee the therapeutic aspects of the activity; and

c. Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act. 29 U.S.C. Sec. 206 as amended, 1966.

C. Personal Housekeeping Patients may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.

D. Payment to patients pursuant to these paragraphs shall not be applied to the costs of hospitalization.

19. Physical Facilities A patient has a right to a humane psychological and physical environment within the hospital facilities. These facilities shall be designed to afford patients with comfort and safety, promote dignity, and ensure privacy. The facilities shall be designed to make a positive contribution to the efficient attainment of the treatment goals of the hospital.

A. Resident Unit

The number of patients in a multi-patient room shall not exceed six persons. There shall be allocated a minimum of 80 square feet of floor space per patient in a multi-patient room. Screens or curtains shall be provided to ensure privacy within the resident unit. Single rooms shall have a minimum of 100 square feet of floor space. Each patient will be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, a chair, and a bedside table.

B. Toilets and Lavatories

There will be one toilet provided for each eight patients and one lavatory for each six patients. A lavatory will be provided with each toilet facility. The toilets will be installed in separate stalls to ensure privacy, will be clean and free of odor, and will be equipped with appropriate safety devices for the physically handicapped.

C. Showers

There will be one tub or shower for each 15 patients. If a central bathing area is provided,

each shower area will be divided by curtains to ensure privacy. Showers and tubs will be equipped with adequate safety accessories.

D. Day Room

The minimum day room area shall be 40 square feet per patient. Day rooms will be attractive and adequately furnished with reading lamps, tables, chairs, television and other recreational facilities. They will be conveniently located to patients' bedrooms and shall have outside windows. There shall be at least one day room area on each bedroom floor in a multi-story hospital. Areas used for corridor traffic cannot be counted as day room space; nor can a chapel with fixed pews be counted as a day room area.

E. Dining Facilities

The minimum dining room area shall be ten square feet per patient. The dining room shall be separate from the kitchen and will be furnished with comfortable chairs and tables with hard, washable surfaces.

F. Linen Servicing and Handling

The hospital shall provide adequate facilities and equipment for handling clean and soiled bedding and other linen. There must be frequent changes of bedding and other linen, no less than every seven days to assure patient comfort.

G. Housekeeping

Regular housekeeping and maintenance procedures which will ensure that the hospital is maintained in a safe, clean, and attractive condition will be developed and implemented.

H. Geriatric and Other Nonambulatory Mental Patients

There must be special facilities for geriatric and other nonambulatory patients to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory patients to communicate their needs to staff.

I. Physical Plant

(1) Pursuant to an established routine maintenance and repair program, the physical plant shall be kept in a continuous state of good repair and operation in accordance with the needs of the health, comfort, safety and well-being of the patients.

(2) Adequate heating, air conditioning and ventilation systems and equipment shall be afforded to maintain temperatures and air changes which are required for the comfort of patients at all times and the removal of undesired heat, steam and offensive odors. Such facilities shall ensure that the temperature in the hospital shall not exceed 83° F nor fall below 68° F.

(3) Thermostatically controlled hot water shall be provided in adequate quantities and maintained at the required temperature for patient or resident use (110° F at the fixture) and for mechanical dishwashing and laundry use (180° F at the equipment).

(4) Adequate refuse facilities will be provided so that solid waste, rubbish and other refuse will be collected and disposed of in a manner which will prohibit transmission of disease and not create a nuisance or fire hazard or provide a breeding place for rodents and insects.

(5) The physical facilities must meet all fire and safety standards established by the state and locality. In addition, the hospital shall meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to hospitals.

19A. The hospital shall meet all standards established by the state for general hospitals, insofar as they are relevant to psychiatric facilities.

20. Nutritional Standards

Patients, except for the non-mobile, shall eat or be fed in dining rooms. The diet for patients will provide at a minimum the Recommended Daily Dietary Allowances as developed by the National Academy of Sciences. Menus shall be satisfying and nutritionally adequate to provide the Recommended Daily Dietary Allowances. In developing such menus, the hospital will utilize the Low Cost Food Plan of the Department of Agriculture. The hospital will not spend less per patient for raw food, including the value of donated food, than the most recent per person costs of the Low Cost Food Plan for the Southern Region of the United States, as compiled by the United States Department of Agriculture, for appropriate groupings of patients, discounted for any savings which might result from institutional procurement of such food. Provisions shall be made for special therapeutic diets and for substitutes at the request of the patient, or his guardian or next of kin, in accordance with the religious requirements of any patient's faith. Denial of a nutritionally adequate diet shall not be used as punishment.

III. QUALIFIED STAFF IN NUMBERS SUFFICIENT TO ADMINISTER ADEQUATE TREATMENT.

21. Each Qualified Mental Health Professional shall meet all licensing and certification requirements promulgated by the State of Alabama for persons engaged in private practice of the same profession elsewhere in Alabama. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their speciality elsewhere in Alabama.

22. a. All Non-Professional Staff Members who have not had prior clinical experience in a mental institution shall have a substantial orientation training.

b. Staff members on all levels shall have regularly scheduled in-service training.

23. Each Non-Professional Staff Member shall be under the direct supervision of a Qualified Mental Health Professional.

24. Staffing Ratios

The hospital shall have the following minimum numbers of treatment personnel per 250 patients. Qualified Mental Health Professionals trained in particular disciplines may in appropriate situations perform services or functions traditionally performed by members of other disciplines. Changes in staff deployment may be made with prior approval of this Court upon a clear and convincing demonstration that the proposed deviation from this staffing structure will enhance the treatment of the patients.

CLASSIFICATION	NUMBER OF EMPLOYEES
Unit Director	1
Psychiatrist (3 years residency training in psychiatry)	2
MD (Registered physicians)	4
Nurses (RN)	12
Licensed Practical Nurses	6
Aide III	6
Aide II	16
Aide I	70
Hospital Orderly	10
Clerk Stenographer II	3
Clerk Typist II	3
Unit Administrator	1
Administrative Clerk	1
Psychologist (Ph. D.) (doctoral degree from accredited program)	1
Psychologist (M.A.)	1
Psychologist (B.S.)	2
Social Worker (MSW) (from accredited program)	2
Social Worker (B.A.)	5
Patient Activity Therapist (M.S.)	1
Patient Activity Aide	10
Mental Health Technician	10
Dental Hygienist	1
Chaplain	.5
Vocational Rehabilitation Counselor	1
Volunteer Services Worker	1
Mental Health Field Representative	1
Dietitian	1
Food Service Supervisor	1
Cook II	2
Cook I	3
Food Service Worker	15
Vehicle Driver	1
Housekeeper	10
Messenger	1
Maintenance Repairman	2

IV. INDIVIDUALIZED TREATMENT PLANS

25. Each patient shall have a comprehensive physical and mental examination and review of behavioral status within 48 hours after admission to the hospital.

26. Each patient shall have an individualized treatment plan. This plan shall be developed by appropriate Qualified Mental Health Professionals, including a psychiatrist, and implemented as soon as possible - in any event no later than five days after the patient's admission. Each individualized treatment plan shall contain:

a. a statement of the nature of the specific problems and specific needs of the patient;

b. a statement of the least restrictive treatment conditions necessary to achieve the purposes of commitment;

c. a description of intermediate and long-range treatment goals, with a projected timetable for their attainment;

d. a statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

e. a specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these treatment goals;

f. criteria for release to less restrictive treatment conditions, and criteria for discharge;

g. a notation of any therapeutic tasks and labor to be performed by the patient in accordance with Standard 18.

27. As part of his treatment plan, each patient shall have an individualized post-hospitalization plan. This plan shall be developed by a Qualified Mental Health Professional as soon as practicable after the patient's admission to the hospital.

28. In the interests of continuity of care, whenever possible, one Qualified Mental Health Professional (who need not have been involved with the development of the treatment plan) shall be responsible for supervising the implementation of the treatment plan, integrating the various aspects of the treatment program and recording the patient's progress. This Qualified Mental Health Professional shall also be responsible for ensuring that the patient is released, where appropriate, into a less restrictive form of treatment.

29. The treatment plan shall be continuously reviewed by the Qualified Mental Health Professional responsible for supervising the implementation of the plan and shall be modified if necessary. Moreover, at least every 90 days, each patient shall receive a mental examination from, and his treatment plan shall be reviewed by, a Qualified Mental Health Professional other than the professional responsible for supervising the implementation of the plan.

30. In addition to treatment for mental disorders, patients confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis.[1] In providing medical care, the State Board of Mental Health shall take advantage of whatever community based facilities are appropriate and available and shall coordinate the patient's treatment for mental illness with his medical treatment.

31. Complete patient records shall be kept on the ward in which the patient is placed and shall be available to anyone properly authorized in writing by the patient. These records shall include:

a. Identification data, including the patient's legal status;

b. A patient history, including but not limited to:

(1) family data, educational background, and employment record;

(2) prior medical history, both physical and mental, including prior hospitalization;

c. The chief complaints of the patient and the chief complaints of others regarding the patient;

d. An evaluation which notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretative, fashion;

e. A summary of each physical examination which describes the results of the examination;

f. A copy of the individual treatment plan and any modifications thereto;

g. A detailed summary of the findings made by the reviewing Qualified Mental Health Professional after each periodic review of the treatment plan which analyzes the successes and failures of the treatment program and directs whatever modifications are necessary;

h. A copy of the individualized post-hospitalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;

i. A medication history and status, which includes the signed orders of the prescribing physician. Nurses shall indicate by signature that orders have been carried out;

j. A detailed summary of each significant contact by a Qualified Mental Health Professional with the patient;

k. A detailed summary on at least a weekly basis by a Qualified Mental Health Professional involved in the patient's treatment of the patient's progress along the treatment plan;

l. A weekly summary of the extent and nature of the patient's work activities described in Standard 18, *supra*, and the effect of such activity upon the patient's progress along the treatment plan;

m. A signed order by a Qualified Mental Health Professional for any restrictions on visitations and communication, as provided in Standards 4 and 5, *supra*;

(1) Approximately 50 patients at Bryce-Searcy are tubercular as also are approximately four residents at Partlow.

n. A signed order by a Qualified Mental Health Professional for any physical restraints and isolation, as provided by Standard 7, *supra*;

o. A detailed summary of any extraordinary incident in the hospital involving the patient to be entered by a staff member noting that he has personal knowledge of the incident or specifying his other source of information, and initialed within 24 hours by a Qualified Mental Health Professional;

p. A summary by the superintendent of the hospital or his appointed agent of his findings after the 15-day review provided for in Standard 33, *infra*.

32. In addition to complying with all the other standards herein, a hospital shall made special provisions for the treatment of patients who are children and young adults. These provisions shall include but are not limited to:

a. Opportunities for publicly supported education suitable to the educational needs of the patient. This program of education must, in the opinion of the attending Qualified Mental Health Professional, be compatible with the patient's mental condition and his treatment program, and otherwise be in the patient's best interest.

b. A treatment plan which considers the chronological, maturational, and developmental level of the patient;

c. Sufficient Qualified Mental Health Professionals, teachers, and staff members with specialized skills in the care and treatment of children and young adults;

d. Recreation and play opportunities in the open air where possible and appropriate residential facilities;

e. Arrangements for contact between the hospital and the family of the patient.

33. No later than 15 days after a patient is committed to the hospital, the superintendent of the hospital or his appointed, professionally qualified agent shall examine the committed patient and shall determine whether the patient continues to require hospitalization and whether a treatment plan complying with Standard 26 has been implemented. If the patient no longer requires hospitalization in accordance with the standards for commitment, or if a treatment plan has not been implemented, he must be released immediately unless he agrees to continue with treatment on a voluntary basis.

34. The Mental Health Board and its agents have an affirmative duty to provide adequate transitional treatment and care for all patients released after a period of involuntary confinement. Transitional care and treatment possibilities include, but are not limited to, psychiatric day care, treatment in the home by a visiting therapist, nursing home or extended care, out-patient treatment, and treatment in the psychiatric ward of a general hospital.

V. MISCELLANEOUS

35. Each patient and his family, guardian, or next friend shall promptly upon the patient's admission receive written notice, in language he understands, of all the above standards for adequate treatment. In addition a copy of all the above standards shall be posted in each ward.

COURT-ORDERED STANDARDS FOR
PARTLOW STATE SCHOOL AND HOSPITAL

I. DEFINITIONS

The terms used herein below are defined as follows:

a. "Institution" – Partlow State School and Hospital.

b. "Residents" – All persons who are now confined and all persons who may in the future be confined at Partlow State School and Hospital.

c. "Qualified Mental Retardation Professional" –

(1) a psychologist with a doctoral or master's degree from an accredited program and with specialized training or one year's experience in treating the mentally retarded;

(2) a physician licensed to practice in the State of Alabama, with specialized training or one year's experience in treating the mentally retarded;

(3) an educator with a master's degree in special education from an accredited program;

(4) a social worker with a master's degree from an accredited program and with specialized training or one year's experience in working with the mentally retarded;

(5) a physical, vocational or occupational therapist licensed to practice in the State of Alabama who is a graduate of an accredited program in physical, vocational or occupational therapy, with specialized training or one year's experience in treating the mentally retarded;

(6) a registered nurse with specialized training or one year of experience treating the mentally retarded under the supervision of a Qualified Mental Retardation Professional.

d. "Resident Care Worker" – an employee of the institution, other than a Qualified Mental Retardation Professional, whose duties require regular contact with or supervision of residents.

e. "Habilitation" – the process by which the staff of the institution assists the resident to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental, and social efficiency. Habilitation includes but is not limited to programs of formal, structured education and treatment.

f. "Education" – the process of formal training and instruction to facilitate the intellectual and emotional development of residents.

g. "Treatment" – the prevention, amelioration and/or cure of a resident's physical disabilities or illnesses.

h. "Guardian" – a general guardian of a resident, unless the general guardian is missing, indifferent to the welfare of the resident or has an interest adverse to the resident. In such a case, *guardian* shall be defined as an individual appointed by an appropriate court on the motion of the superintendent, such guardian not to be in the control or in the employ of the Alabama Board of Mental Health.

i. "Express and Informed Consent" – the uncoerced decision of a resident who has comprehension and can signify assent or dissent.

II. ADEQUATE HABILITATION OF RESIDENTS

1. Residents shall have a right to habilitation, including medical treatment, education and care, suited to their needs, regardless of age, degree of retardation or handicapping condition.

2. Each resident has a right to a habilitation program which will maximize his human abilities and enhance his ability to cope with his environment. The institution shall recognize that each resident, regardless of ability or status, is entitled to develop and realize his fullest potential. The institution shall implement the principle of normalization so that each resident may live as normally as possible.

3. a. No person shall be admitted to the institution unless a prior determination shall have been made[1] that residence in the institution is the least restrictive habilitation setting feasible for that person.

b. No mentally retarded person shall be admitted to the institution if services and programs in the community can afford adequate habilitation to such person.

c. Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, the institution shall make every attempt to move residents from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residence; (5) segregated from the community to integrated into the community living; (6) dependent to independent living.

4. No borderline or mildly mentally retarded person shall be a resident of the institution. For purposes of this standard, a borderline retarded person is defined as an individual who is functioning between one and two standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on measures of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale. A mildly retarded person is defined as an individual who is functioning between two and three standard deviations below the mean on the standardized intelligence test such as the Stanford Binet Scale and on a measure of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale.

(1) See Standard 7, *Infra*.

5. Residents shall have a right to receive suitable educational services regardless of chronological age, degree of retardation or accompanying disabilities or handicaps.

a. The institution shall formulate a written statement of educational objectives that is consistent with the institution's mission as set forth in Standard 2, *supra*, and the other standards proposed herein.

b. School-age residents shall be provided a full and suitable educational program. Such educational programs shall meet the following minimum standards:

		Mild [2]	Moderate	Severe/Profound
(1)	Class Size	12	9	6
(2)	Length of school year (in months)	9-10	9-10	11-12
(3)	Minimum length of school day (in hours)	6	6	6

6. Residents shall have a right to receive prompt and adequate medical treatment for any physical ailments and for the prevention of any illness or disability. Such medical treatment shall meet standards of medical practice in the community.

III. INDIVIDUALIZED HABILITATION PLANS

7. Prior to his admission to the institution, each resident shall have a comprehensive social, psychological, educational, and medical diagnosis and evaluation by appropriate specialists to determine if admission is appropriate.

a. Unless such preadmission evaluation has been conducted within three months prior to the admission, each resident shall have a new evaluation at the institution to determine if admission is appropriate.

b. When undertaken at the institution, preadmission diagnosis and evaluation shall be completed within five days.

8. Within 14 days of his admission to the institution, each resident shall have an evaluation by appropriate specialists for programming purposes.

9. Each resident shall have an individualized habilitation plan formulated by the institution. This plan shall be developed by appropriate Qualified Mental Retardation Professionals and implemented as soon as possible but no later than 14 days after the resident's admission to the institution. An interim program of habilitation, based on the preadmission evaluation conducted pursuant to Standard 7, *supra*, shall commence promptly upon the resident's admission. Each individualized

(2) As is reflected in Standard 4, supra, it is contemplated that no mildly retarded persons be residents of the institution. However, until those mildly retarded who are presently residents are removed to more suitable locations and/or facilities, some provision must be made for their educational program.

habilitation plan shall contain:

a. a statement of the nature of the specific limitations and specific needs of the resident;

b. a description of intermediate and long-range habilitation goals with a projected timetable for their attainment;

c. a statement of, and an explanation for, the plan of habilitation for achieving these intermediate and long-range goals;

d. a statement of the least restrictive setting for habilitation necessary to achieve the habilitation goals of the resident;

e. a specification of the professionals and other staff members who are responsible for the particular resident's attaining these habilitation goals;

f. criteria for release to less restrictive settings for habilitation, including criteria for discharge and a projected date for discharge.

10. As part of his habilitation plan, each resident shall have an individualized post-institutionalization plan. This plan shall be developed by a Qualified Mental Retardation Professional who shall begin preparation of such plan prior to the resident's admission to the institution and shall complete such plan as soon as practicable. The guardian or next of kin of the resident and the resident, if able to give informed consent, shall be consulted in the development of such plan and shall be informed of the content of such plan.

11. In the interests of continuity of care, one Qualified Mental Retardation Professional shall be responsible for supervising the implementation of the habilitation plan, integrating the various aspects of the habilitation program, and recording the resident's progress as measured by objective indicators. This Qualified Mental Retardation Professional shall also be responsible for ensuring that the resident is released when appropriate to a less restrictive habilitation setting.

12. The habilitation plan shall be continuously reviewed by the Qualified Mental Retardation Professional responsible for supervising the implementation of the plan and shall be modified if necessary. In addition, six months after admission and at least annually thereafter, each resident shall receive a comprehensive psychological, social, educational and medical diagnosis and evaluation, and his habilitation plan shall be reviewed by an interdisciplinary team of no less than two Qualified Mental Retardation Professionals and such resident care workers as are directly involved in his habilitation and care.

13. In addition to habilitation for mental disorders, people confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis.[3] In providing medical care, the State Board of Mental Health shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the resident's habilitation

(3) Approximately 50 patients at Bryce-Searcy are tubercular as also are approximately four residents at Parlow.

for mental retardation with his medical treatment.

14. Complete records for each resident shall be maintained and shall be readily available to Qualified Mental Retardation Professionals and to the resident care workers who are directly involved with the particular resident. All information contained in a resident's records shall be considered privileged and confidential. The guardian, next of kin, and any person properly authorized in writing by the resident, if such resident is capable of giving informed consent, or by his guardian or next of kin, shall be permitted access to the resident's records. These records shall include:

a. Identification data, including the resident's legal status;

b. The resident's history, including but not limited to:

(1) family data, educational background, and employment record;

(2) prior medical history, both physical and mental, including prior institutionalization;

c. The resident's grievances if any;

d. An inventory of the resident's life skills;

e. A record of each physical examination which describes the results of the examination;

f. A copy of the individual habilitation plan and any modifications thereto and an appropriate summary which will guide and assist the resident care workers in implementing the resident's program;

g. The findings made in periodic reviews of the habilitation plan (see Standard 12, *supra*), which findings shall include an analysis of the successes and failures of the habilitation program and shall direct whatever modifications are necessary;

IV. HUMANE PHYSICAL AND PSYCHOLOGICAL ENVIRONMENT

15. Residents shall have a right to dignity, privacy and humane care.

16. Residents shall lose none of the rights enjoyed by citizens of Alabama and of the United States solely by reason of their admission or commitment to the institution, except as expressly determined by an appropriate court.

17. No person shall be presumed mentally incompetent solely by reason of his admission or commitment to the institution.

18. The opportunity for religious worship shall be accorded to each resident who desires such worship. Provisions for religious worship shall be made available to all residents on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.

19. Residents shall have the same rights to telephone communication as patients at Alabama public hospitals, except to the extent that a Qualified Mental Retardation Professional responsible for formulation of a particular resident's habilitation plan (see Standard 9, *supra*) writes an order imposing

special restrictions and explains the reasons for any such restrictions. The written order must be renewed semiannually if any restrictions are to be continued. Residents shall have an unrestricted right to visitation, except to the extent that a Qualified Mental Retardation Professional responsible for formulation of a particular resident's habilitation plan (see Standard 9, *supra*) writes an order imposing special restrictions and explains the reasons for any such restrictions. The written order must be renewed semiannually if any restrictions are to be continued.

h. A copy of the post-institutionalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;

i. A medication history and status, pursuant to Standard 22, *Infra*;

j. A summary of each significant contact by a Qualified Mental Retardation Professional with a resident;

k. A summary of the resident's response to his program, prepared by a Qualified Mental Retardation Professional involved in the resident's habilitation and recorded at least monthly. Such response, wherever possible, shall be scientifically documented.

l. A monthly summary of the extent and nature of the resident's work activities described in the Standard 33(b), *Infra* and the effect of such activity upon the resident's progress along the habilitation plan;

m. A signed order by a Qualified Mental Retardation Professional for any physical restraints, as provided in Standard 26(a)(1), *Infra*;

n. A description of any extraordinary incident or accident in the institution involving the resident, to be entered by a staff member noting personal knowledge of the incident or accident or other source of information, including any reports of investigations of residents mistreatment, as required by Standard 28, *Infra*;

o. A summary of family visits and contacts;

p. A summary of attendance and leaves from the institution;

q. A record of any seizures, illnesses, treatments thereof, and immunizations.

20. Residents shall be entitled to send and receive sealed mail. Moreover, it shall be the duty of the institution to facilitate the exercise of this right by furnishing the necessary materials and assistance.

21. The institution shall provide, under appropriate supervision, suitable opportunities for the resident's interaction with members of the opposite sex, except where a Qualified Mental Retardation Professional responsible for the formulation of a particular resident's habilitation plan writes an order to the contrary and explains the reasons therefor.

22. Medication:

a. No medication shall be administered unless at the written order of a physician.

b. Notation of each individual's medication shall be kept in his medical records (Standard 14(i) *supra*). At least weekly the attending physician shall review the drug regimen of each resident under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days.

c. Residents shall have a right to be free from unnecessary or excessive medication. The resident's records shall state the effects of psycho-active medication on the resident. When dosages of such are changed or other psychoactive medications are prescribed, a notation shall be made in the resident's record concerning the effect of the new medication or new dosages and the behavior changes, if any, which occur.

d. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a habilitation program, or in quantities that interfere with the resident's habilitation program.

e. Pharmacy services at the institution shall be directed by a professionally competent pharmacist licensed to practice in the State of Alabama. Such pharmacist shall be a graduate of a school of pharmacy accredited by the American Council on Pharmaceutical Education. Appropriate officials of the institution, at their option, may hire such a pharmacist or pharmacists fulltime, or, in lieu thereof, contract with outside pharmacists.

f. Whether employed fulltime or on a contract basis, the pharmacist shall perform duties which include but are not limited to the following:

(1) Receiving the original, or direct copy, of the physician's drug treatment order;

(2) Reviewing the drug regimen, and any changes, for potentially adverse reactions, allergies, interactions, contraindications, rationality, and laboratory test modifications and advising the physician of any recommended changes, with reasons and with an alternate drug regimen;

(3) Maintaining for each resident an individual record of all medications (prescription and nonprescription) dispensed, including quantities and frequency of refills;

(4) Participating, as appropriate, in the continuing interdisciplinary evaluation of individual residents for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs.

g. Only appropriately trained staff shall be allowed to administer drugs.

23. Seclusion, defined as the placement of a resident alone in a locked room, shall not be employed. Legitimate "time out" procedures may be utilized under close and direct professional supervision as a technique in behavior-shaping programs.

24. Behavior modification programs involving the use of noxious or aversive stimuli shall be reviewed and approved by the institution's Human Rights Committee and shall be conducted only with the express and informed consent of the affected resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such behavior modification programs shall be conducted only under the supervision of and in the presence of a Qualified Mental Retardation Professional who has had proper training in such techniques.

25. Electric shock devices shall be considered a research technique for the purpose of these standards. Such devices shall only be used in extraordinary circumstances to prevent selfmutilation leading to repeated and possibly permanent physical damage to the resident and only after alternative techniques have failed. The use of such devices shall be subject to the conditions prescribed in Standard 24, *supra*, and Standard 29, *infra*, and shall be used only under the direct and specific order of the superintendent.

26. Physical restraint shall be employed only when absolutely necessary to protect the resident from injury to himself or to prevent injury to others. Restraint shall not be employed as punishment, for the convenience of staff, or as a substitute for a habilitation program. Restraint shall be applied only if alternative techniques have failed and only if such restraint imposes the least possible restriction consistent with its purpose.

a. Only Qualified Mental Retardation Professionals may authorize the use of restraints.

(1) Orders for restraints by the Qualified Mental Retardation Professionals shall be in writing and shall not be in force for longer than 12 hours.

(2) A resident placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, and a record of such checks shall be kept.

(3) Mechanical restraints shall be designed and used so as not to cause physical injury to the resident and so as to cause the least possible discomfort.

(4) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which restraint is employed.

(5) Daily reports shall be made to the superintendent by those Qualified Mental Retardation Professionals ordering the use of restraints, summarizing all such uses of restraint, the types used, the duration, and the reasons therefor.

b. The institution shall cause a written statement of this policy to be posted in each living

unit and circulated to all staff members.

27. Corporal punishment shall not be permitted.

28. The institution shall prohibit mistreatment, neglect or abuse in any form of any resident.

a. Alleged violations shall be reported immediately to the superintendent and there shall be a written record that:

(1) Each alleged violation has been thoroughly investigated and findings stated;

(2) The results of such investigation are reported to the superintendent and to the commissioner within 24 hours of the report of the incident. Such reports shall also be made to the institution's Human Rights Committee monthly and to the Alabama Board of Mental Health at its next scheduled public meeting.

b. The institution shall cause a written statement of this policy to be posted in each cottage and building and circulated to all staff members.

29. Residents shall have a right not to be subjected to experimental research without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the institution's Human Rights Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.

30. Residents shall have a right not to be subjected to any unusual or hazardous treatment procedures without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and legal counsel. Such proposed procedures shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought.

31. Residents shall have a right to regular physical exercise several times a week. It shall be the duty of the institution to provide both indoor and outdoor facilities and equipment for such exercise.

32. Residents shall have a right to be outdoors daily in the absence of contrary medical considerations.

33. The following rules shall govern resident labor:

a. Institution Maintenance

(1) No resident shall be required to perform labor which involves the operation and maintenance of the institution or for which the institution is under contract with an

outside organization. Privileges or release from the institution shall not be conditioned upon the performance of labor covered by this provision. Residents may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. Sec. 206, as amended, 1966.

(2) No resident shall be involved in the care(feeding, clothing, bathing), training or supervision of other residents unless he:

(a) has volunteered;

(b) has been specifically trained in the necessary skills;

(c) has the humane judgment required for such activities;

(d) is adequately supervised; and

(e) is reimbursed in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. Sec. 206 as amended, 1966.

b. Training Tasks and Labor

(1) Residents may be required to perform vocational training tasks which do not involve the operation and maintenance of the institution, subject to a presumption that an assignment of longer than three months to any task is not a training task, provided the specific task or any change in task assignment is:

(a) An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;

(b) Supervised by a staff member to oversee the habilitation aspects of the activity.

(2) Residents may voluntarily engage in habilitative labor at nonprogram hours for which the institution would otherwise have to pay an employee, provided the specific labor or any change in labor is:

(a) An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;

(b) Supervised by a staff member to oversee the habilitation aspects of the activity; and

(c) Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. Sec. 206 as amended, 1966.

c. Personal Housekeeping Residents may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.

d. Payment to residents pursuant to this paragraph shall not be applied to the costs of institutionalization.

e. Staffing shall be sufficient so that the institution is not dependent upon the use of residents or volunteers for the care, maintenance or habilitation of other residents or for income-producing services. The institution shall formulate a written policy to protect the residents from exploitation when they are engaged in productive work.

34. A nourishing, well-balanced diet shall be provided each resident.

a. The diet for residents shall provide at a minimum the Recommended Daily Dietary Allowance as developed by the National Academy of Sciences. Menus shall be satisfying and shall provide the Recommended Daily Dietary Allowances. In developing such menus, the institution shall utilize the Moderate Cost Food Plan of the United States Department of Agriculture. The institution shall not spend less per patient for raw food, including the value of donated food, than the most recent per person costs of the Moderate Cost Food Plan for the Southern Region of the United States, as compiled by the United States Department of Agriculture, for appropriate groupings of residents, discounted for any savings which might result from institutional procurement of such food.

b. Provisions shall be made for special therapeutic diets and for substitutes at the request of the resident, or his guardian or next of kin, in accordance with the religious requirements of any resident's faith.

c. Denial of a nutritionally adequate diet shall not be used as punishment.

d. Residents, except for the non-mobile, shall eat or be fed in dining rooms.

35. Each resident shall have an adequate allowance of neat, clean, suitably fitting and seasonable clothing.

a. Each resident shall have his own clothing, which is properly and inconspicuously marked with his name, and he shall be kept dressed in this clothing. The institution has an obligation to supply an adequate allowance of clothing to any residents who do not have suitable clothing of their own. Residents shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the resident's throughout his stay in the institution.

b. Clothing both in amount and type shall make it possible for residents to go out of doors in inclement weather, to go for trips or visits appropriately dressed, and to make a normal appearance in the community.

c. Nonambulatory residents shall be dressed daily in their own clothing, including shoes, unless contraindicated in written medical orders.

d. Washable clothing shall be designed for multiply handicapped residents being trained in self-help skills, in accordance with individual needs.

e. Clothing for incontinent residents shall be designed to foster comfortable sitting, crawling and/or walking, and toilet training.

f. A current inventory shall be kept of each resident's personal and clothing items.

g. The institution shall make provision for the adequate and regular laundering of the residents' clothing.

36. Each resident shall have the right to keep and use his own personal possessions except insofar as such clothes or personal possessions may be determined to be dangerous, either to himself or to others, by a Qualified Mental Retardation Professional.

37. a. Each resident shall be assisted in learning normal grooming practices with individual toilet articles, including soap and toothpaste, that are available to each resident.

b. Teeth shall be brushed daily with an effective dentifrice. Individual brushes shall be properly marked, used and stored.

c. Each resident shall have a shower or tub bath at least daily, unless medically contraindicated.

d. Residents shall be regularly scheduled for hair cutting and styling, in an individualized manner, by trained personnel.

e. For residents who require such assistance, cutting of toenails and fingernails shall be scheduled at regular intervals.

38. Physical Facilities A resident has a right to a humane physical environment within the institutional facilities. These facilities shall be designed to make a positive contribution to the efficient attainment of the habilitation goals of the institution.

a. Resident Unit All ambulatory residents shall sleep in single rooms or in multi-resident rooms of no more than six persons. The number of nonambulatory residents in a multi-resident room shall not exceed ten persons. There shall be allocated a minimum of 80 square feet of floor space per resident in a multi-resident room. Screens or curtains shall be provided to ensure privacy. Single rooms shall have a minimum of 100 square feet of floor space. Each resident shall be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, and appropriate furniture such as a chair and a bedside table, unless contraindicated by a Qualified Mental Retardation Professional who shall state the reasons for any such restriction.

b. Toilets and Lavatories There shall be one toilet and one lavatory for each six residents. A lavatory shall be provided with each toilet facility. The toilets shall be installed in separate stalls for ambulatory residents, or in curtained areas for non-ambulatory residents, to ensure privacy, shall be clean and free of odor, and shall be equipped with appropriate safety devices for the physically handicapped. Soap and towels and/or drying mechanisms shall be available in each lavatory. Toilet paper shall be available in each toilet facility.

c. Showers There shall be one tub or shower for each eight residents. If a central bathing area is provided, each tub or shower shall be divided by curtains to ensure privacy. Showers and tubs shall be equipped with adequate safety accessories.

d. Day Room The minimum day room area shall be 40 square feet per resident. Day rooms shall be attractive and adequately furnished with reading lamps, tables, chairs, television, radio and other recreational facilities. They shall be conveniently located to residents' bedrooms and shall have outside windows. There shall be at least one day room area on each bedroom floor in a multi-story facility. Areas used for corridor traffic shall not be counted as day room space; nor shall a chapel with fixed pews be counted as a day room area.

e. Dining Facilities The minimum dining room area shall be ten square feet per resident. The dining room shall be separate from the kitchen and shall be furnished with comfortable chairs and tables with hard, washable surfaces.

f. Linen Servicing and Handling The institution shall provide adequate facilities and equipment for the expeditious handling of clean and soiled bedding and other linen. There must be frequent changes of bedding and other linen, but in any event no less than every seven days, to assure sanitation and resident comfort. After soiling by an incontinent resident, bedding and linen must immediately be changed and removed from the living unit. Soiled linen and laundry shall be removed from the living unit daily.

g. Housekeeping Regular housekeeping and maintenance procedures which will ensure that the institution is maintained in a safe, clean and attractive condition shall be developed and implemented.

h. Nonambulatory Residents There must be special facilities for nonambulatory residents to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory residents to communicate their needs to staff.

i. Physical Plant

(1) Pursuant to an established routine maintenance and repair program, the physical plant shall be kept in a continuous state of good repair and operation so as to ensure the health, comfort, safety and well-being of the residents and so as not to impede in any manner the habilitation programs of the residents.

(2) Adequate heating, air conditioning and ventilation systems and equipment shall be afforded to maintain temperatures and air changes which are required for the comfort of residents at all times. Ventilation systems shall be adequate to remove steam and offensive odors or to mask such odors. The temperature in the institution shall not exceed 83 degrees F nor fall below 68 degrees F.

(3) Thermostatically controlled hot water shall be provided in adequate quantities and maintained at the required temperature for resident use (110 degrees F at the fixture) and for mechanical dishwashing and laundry use (180 degrees F at the equipment). Thermostatically controlled hot water valves shall be equipped with a double valve system that provides both auditory and visual signals of valve failures.

(4) Adequate refuse facilities shall be provided so that solid waste, rubbish and other refuse will be collected and disposed of in a manner which will prohibit transmission of disease and not create a nuisance or fire hazard or provide a breeding place for rodents and insects.

(5) The physical facilities must meet all fire and safety standards established by the state and locality. In addition, the institution shall meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to it.

V. QUALIFIED STAFF IN NUMBERS SUFFICIENT TO PROVIDE ADEQUATE HABILITATION

39. Each Qualified Mental Retardation Professional and each physician shall meet all licensing and certification requirements promulgated by the State of Alabama for persons engaged in private practice of the same profession elsewhere in Alabama. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their specialty elsewhere in Alabama.

a. All resident care workers who have not had prior clinical experience in a mental retardation institution shall have suitable orientation training.

b. Staff members on all levels shall have suitable, regularly scheduled in-service training.

40. Each resident care worker shall be under the direct professional supervision of a Qualified Mental Retardation Professional.

41. Staffing Ratios

a. Qualified staff in numbers sufficient to administer adequate habilitation shall be provided. Such staffing shall include but not be limited to the following fulltime professional and special services. Qualified Mental Retardation Professionals trained in particular disciplines may in appropriate situations perform services or functions traditionally performed by members of other disciplines. Substantial changes in staff deployment may be made with the prior approval of this Court upon a clear and convincing demonstration that the proposed deviation from this staffing structure would enhance the habilitation of the residents. Professional staff shall possess the qualifications of Qualified Mental Retardation Professionals as defined herein unless expressly stated otherwise.

b.

Unit	Mild [4]	Moderate	Severe/Profound
	60	60	60
(1) Psychologists	1:60	1:60	1:60
(2) Social Workers	1:60	1:60	1:60
(3) Special Educators (shall include an equal number of master's degree and bachelor's degree holders in special education)	1:15	1:10	1:30
(4) Vocational Therapists	1:60	1:60	--
(5) Recreational Therapists (shall be master's degree graduates from an accredited program)	1:60	1:60	1:60
(6) Occupational Therapists	--	--	1:60
(7) Registered Nurses	1:60	1:60	1:12
(8) Resident Care Workers	1:2.5	1:1.25	1:1

The following professional staff shall be fulltime employees of the institution who shall not be assigned to a single unit but who shall be available to meet the needs of any resident of the institution:

Physicians	1:200
Physical Therapists	1:100
Speech and Hearing Therapists	1:100
Dentists [5]	1:200

(4) See n. 2, *supra*.

(5) Defendants may, in lieu of employing fulltime dentists, contract outside the institution for dental care. In this event the dental services provided the residents must include (a) complete dental examinations and appropriate corrective dental work for each resident each six months and (b) a dentist on call 24 hours per day for emergency work.

Social Workers (shall be principally involved in the placement of residents in the community and shall include bachelor's degree graduates from an accredited program in social work)	1:80
Chaplains [6]	1:200

c. Qualified medical specialists of recognized professional ability shall be available for specialized care and consultation. Such specialist services shall include a psychiatrist on a one-day per week basis, a psychologist on a two-day per week basis, and any other medical or health-related speciality available in the community.

VI. MISCELLANEOUS

42. The guardian or next of kin of each resident shall promptly upon resident's admission receive a written copy of all the above standards for adequate habilitation. Each resident, if the resident is able to comprehend, shall promptly upon his admission be orally informed in clear language of the above standards and, where appropriate, be provided with a written copy.

43. The superintendent shall report in writing to the next of kin or guardian of the resident at least every six months on the resident's educational, vocational and living skills progress and medical condition. Such report shall also state any appropriate habilitation program which has not been afforded to the resident because of inadequate habilitation resources.

44. a. No resident shall be subjected to a behavior modification program designed to eliminate a particular pattern of behavior without prior certification by a physician that he has examined the resident in regard to behavior to be extinguished and finds that such behavior is not caused by a physical condition which could be corrected by appropriate medical procedures.

b. No resident shall be subjected to a behavior modification program which attempts to extinguish socially appropriate behavior or to develop new behavior patterns when such behavior modifications serve only institutional convenience.

45. No resident shall have any of his organs removed for the purpose of transplantation without compliance with the procedures set forth in Standard 30, *supra*, and after a court hearing on such transplantation in which the resident is represented by a guardian *ad litem*. This standard shall apply to any other surgical procedure which is undertaken for reasons other than therapeutic benefit to the resident.

46. Within 90 days of the date of this order, each resident of the institution shall be evaluated as to his mental, emotional, social, and physical condition. Such evaluation or reevaluation shall be

[6] Defendants may, in lieu of employing full time chaplains, recruit, upon the ratio shown above, interfaith volunteer chaplains.

conducted by an interdisciplinary team of Qualified Mental Retardation Professionals who shall use professionally recognized tests and examination procedures. Each resident's guardian, next of kin or legal representative shall be contacted and his readiness to make provisions for the resident's care in the community shall be ascertained. Each resident shall be returned to his family, if adequately habilitated, or assigned to the least restrictive habilitation setting.

47. Each resident discharged to the community shall have a program of transitional habilitation assistance.

48. The institution shall continue to suspend any new admissions of residents until all of the above standards of adequate habilitation have been met.

49. No person shall be admitted to any publicly supported residential institution caring for mentally retarded persons unless such institution meets the above standards.

STATE OF MONTANA

Office of the Governor

Budget and Program Planning

Thomas L. Judge
Governor

Keith L. Colbo
Director

Capitol Building · Helena, Montana 59601

July 22, 1974

MEMORANDUM: Preliminary Draft for Discussion Purposes Only

TO: Keith L. Colbo

FROM: Patrick E. Melby, Staff Attorney PEM

SUBJECT: Legal Rights of the Mentally Handicapped

The area of legal rights of the mentally handicapped is a dynamic, burgeoning field which has just recently sprung to life.

Such national organizations as the Mental Health Law Project and the National Center for Law and the Handicapped Inc. have been exerting tremendous pressure across the nation to establish rights for the mentally ill and the mentally retarded and to ensure that those rights are protected. Recently the United States Justice Department joined in the task and will presumably be a leader in future litigation at both the state and federal levels.

The legal rights of the mentally handicapped cover a broad spectrum ranging from the right to treatment or habilitation to the rights to love, marry and bear children. Because there are many issues involved and because they are in a constant state of flux, I intend to cover only the major areas of concern in this memorandum -- those areas which directly involve the relationships between the mentally handicapped and state institutions.

As stated above, the area of legal rights of the mentally handicapped is in the early stages of development. Cases dealing with the various subjects involved are being decided at such a rapid rate that it is nearly impossible

to keep pace with them. For these reasons I am unable to reiterate the legal rights involved as though they are concrete constitutional principles promulgated by the United States Supreme Court but am confined to merely discussing the recent trends and their general direction.

1. The Civil Commitment Process -- The Right to Due Process of Law

There is no question that basic due process of law is applicable to the civil commitment of the mentally handicapped.[1] What is unanswered is what elements of due process are required before the liberty of an individual may be restrained by the state.

The requirements of due process are not static; they vary depending on the importance of the interests involved and the nature of subsequent proceedings. The relaxation of due process standards in a civil commit proceeding may be partly justified by the state's role as parens patriae -- due process does not forbid involuntary detention for the purposes of rendering care and treatment to a person of unsound mind to protect the interests of that person.

The emerging rule, however, is that even a cursory appraisal of the effects of civil commitment on the interests of those constrained thereby exemplifies the importance of a strict adherence to stringent procedural requirements and the necessity for narrow, precise standards. The interests in avoiding civil commitment are at least as great as those of persons accused of criminal offenses. The resulting burden on the state to prove its case must be correspondingly high. A leading case on this subject today is Lessard v. Schmidt.[2] This is a 1972, three judge, U.S. District Court decision which held Wisconsin's statutory scheme for involuntary civil commitment to be without

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[1] Baxstrom v. Herold, 383 U.S. 107 (1966), Specht v. Patterson, 386 U.S. 605 (1967)

[2] 349 F. Supp. 1078 (E.D. Wis. 1972)

adequate procedural safeguards to protect the interests of persons alleged mentally ill (the same standards would apply to a civil commitment for any alleged mental handicap).

If this decision is upheld by the Supreme Court, it will become a landmark case in the area of procedural due process of law in civil commitment proceedings.[3] At least one other three judge U.S. District Court has already followed the principles enunciated in Lessard.[4]

A discussion of the standards of due process for a civil commitment applied by the court in Lessard v. Schmidt follows.

1. Notice and an opportunity to be heard.

a. The state may sometimes have a compelling interest in the emergency detention of persons who threaten violence to themselves or others for the purpose of protecting society and the individual. However, emergency detention can only be justified for the length of time necessary to arrange for a hearing before a neutral judge at which probable cause for the detention must be established. The maximum period which a person may be detained prior to a preliminary hearing is 48 hours.

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[3] The judgment for injunctive relief ordered by the District Court in Lessard was recently vacated by the Supreme Court. In remanding the case to the lower court for further proceedings, the Supreme Court stated that: "Neither the brief judgment nor the accompanying opinion is specific in outlining the terms of the injunctive relief granted; nor can it be said that the order describes in reasonable detail the act or acts sought to be restrained." It is assumed that the lower court is presently drafting a more detailed and specific order. Schmidt v. Lessard ____ U.S. _____, 38 L. ED. 2d 661, 94 S. Ct. 713 (1974).

[4] Bell v. Wayne County General Hospital, Civil Action No. 36384 (E.D. Mich. S.D., 1974) - As yet unreported.

The preliminary hearing, concluded upon a showing of probable cause for commitment, does not justify a prolonged lapse of time before a full hearing can be held on the necessity of continued confinement. The court held that from ten to fourteen days was the maximum that an individual could be detained without a full hearing.

b. Notice of the full hearing must be given sufficiently in advance of the proceedings to afford reasonable opportunity to prepare and must set forth the basis for detention with particularity.

c. Notice must include the basis for the individual's detention, the right to jury trial, the right to counsel,[5] the standards for detention,[6] the names of the examining physicians and all other persons who may testify in favor of his continued detention, and the substance of their proposed testimony.

Note: Due process is not accorded by an ex parte hearing in which the individual has no meaningful opportunity to be heard.

2. Standards for commitment

Civil confinement can be justified in some cases if the proper burden of proof is satisfied and dangerousness is based upon finding of a recent overt act, attempt or threat to do substantial harm to oneself of others.

The burden of proof placed on the state in Lessard is "beyond a reasonable doubt" on all questions relating to civil commitment.[7]

The argument for such a stringent standard of proof is compelling in the

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[5] The court in Lessard did not specifically require notice of the individual's right to counsel but that requirement is implied. See Dixon v. Att. Gen. of Comm. of Pa., 325 F. Supp. 966 (M.D. Pa. 1971) and Heryford v. Parker, 396 F. 2d 393 (10th Cir. 1968).

[6] See Section 2, Standards for Commitment, which follows.

[7] See also In Re Ballay, 482 F. 2d 648 (D.C. 1973).

case of a civil commitment in which an individual will be deprived of basic civil rights and be stigmatized by the lack of confidentiality of the adjudication.

The court further stated that a". . . basic concept in American justice is the principle that even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose."

With this principle in mind the court ruled the state must bear the burden of exploration of alternatives to commitment and of proving: (1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable.

These alternatives include voluntary or court-ordered out-patient treatment day or night treatment in a hospital, placement in the custody of a friend or relative, referral to a community mental health clinic, and home health aide services.

3. Right to Counsel.

The importance of the interests involved make imperative the assistance of counsel as soon after proceedings are begun as realistically possible.

The appointment of a guardian ad litem cannot satisfy this requirement. Guardians and representative attorneys occupy separate roles. The function of a guardian is to evaluate for himself what is in the best interests of his ward and then proceed, almost independent of the will of his ward to accomplish it. In contrast, the role of the representative attorney is that of an advocate representing the wishes of his client.

The bigger issue relates to the role of counsel in the commitment process.

Must the individual be represented by counsel at every step of the proce
The Court concluded that the individual certainly has the right to have
present at the preliminary hearing on detention, with time enough before
hearing to prepare available initial defenses. And obviously, the subje
the civil commitment proceeding cannot competently decide whether to exe
the right to a jury trial without aid of counsel. The Court, however, d
not require presence of counsel at psychiatric interviews of the subject
felt that other means, such as recording interviews and making them avai
to defense counsel, would adequately protect the individual's rights wit
less disruption to the traditional psychiatrist-patient relationship.

4. The privilege Against Self-Incrimination.

Availability of the privilege against self-incrimination does not t
on the type of proceeding in which its protection is invoked (a civil pr
ceeding as opposed to a criminal proceeding covered by the fifth amendm
but upon the nature of the statement and the exposure it invites. Commi
ment is a deprivation of liberty. It is incarceration against one's wi
whether it is called "criminal" or "civil." No person may be compelled
be a witness against himself when he is threatened with deprivation of
liberty.[8]

Consistent with this principle, a state may not commit individuals
the basis of their statements to psychiatrists in the absence of a show
that the statements were made with knowledge that the individual was no
obliged to speak.

5. Exclusion of Hearsay Evidence.

The weaknesses of hearsay evidence are the same, whatever the natu
the proceeding. Where standard exclusionary rules forbid the admissio

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[8] In re Gault, 387 U.S. 1, 49, 50 (1969) - This case dealt with ci
commitment of a juvenile in a delinquency proceeding.

evidence, no sound policy reasons exist for admitting such evidence in an involuntary commitment proceeding.

The seriousness of the deprivation of liberty and the consequences which follow an adjudication of mental illness make the strict adherence to the rules of evidence applicable to other proceedings, in which an individual's liberty is in jeopardy, imperative.

Due Process in "Voluntary" Admission of the Mentally Retarded

Of equal importance is the right to due process of law of the mentally retarded citizen who is admitted to a state institution on the application of a parent or guardian or other person having lawful custody. A three judge United States District Court recently held Tennessee's laws, regarding the application for the admission of a mentally retarded person to a state institution, unconsitutional as violative of the due process clause of the Fourteenth Amendment. This opinion, Saville v. Treadway,[9] did not elaborate on what elements of due process were required in such a situation, it merely indicated that some form of judicial proceeding was necessary before a person could be admitted to an institution for the mentally retarded on the application of a parent, guardian, or anyone else.

Although this is a case of first impression, it appears to be based on sound legal principles. There are other cases pending on the same subject in which more definitive guidelines are being pursued.[10]

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[9] Civil Action No. 6969 (M.D. Tenn., 1974) - As yet unreported.

[10] e.g., Bartley v. Haverford State Hospital, recently filed in Pennsylvania.

II. The Right to Treatment in Mental Institutions

The development of the right to treatment theory is comprehensible only when the total failure of the mental health system is considered. It developed because many institutions around the country are grossly overcrowded and understaffed and resemble prisons more than they do hospitals. The disparity between professed ideals and actual performance is as great in this area as anywhere.[11]

The theory itself was first advanced publicly in 1960 by Dr. Morton Birnbaum who proposed that the subject of an involuntary civil commitment to a mental institution has a right to treatment.[12]

That proposition did not emerge in a court decision until 1966 when a Federal Circuit Court, in Rouse v. Cameron,[13] determined that the District of Columbia "1964 Hospitalization of the Mentally Ill Act" established a statutory right to treatment for persons involuntarily committed under it. Although the "right to treatment" in this case was based on statutory law, there was substantial dicta in the opinion suggesting that such a right was derived from the Constitution - the due process clause of the fourteenth amendment, the eighth amendment prohibition of cruel and unusual punishment, and the equal protection clause.

David Bazelon, Chief Judge of the District of Columbia Circuit of the United States Courts of Appeals, and a leading jurist in the field of legal rights of the mentally handicapped, has articulated the role of the judiciary in this area: "It makes little sense to guard zealously against the possibilities of unwarranted deprivations prior to hospitalization, only to abandon the watch

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[11] Legal Rights of the Mentally Handicapped, Practising Law Institute, The Mental Health Law Project (1973, Vol. I, p. 275).

[12] Birnbaum, The Right to Treatment, 46 A.B.A. Journal 499 (1960).

[13] 373 F. 2d 451 (1966).

once the patient disappears behind hospital doors."[14]

The most recent major development on this subject is the case of Wyatt v. Stickney,[15] a case of far reaching magnitude that, if upheld, will be the denouement of all litigation on the "right to treatment."

The Wyatt case goes substantially beyond all previous cases on this subject because it (1) was a class action, brought for all persons similarly situated in Alabama's mental institutions, (2) was clearly based on a constitutional right to treatment, (3) applied the right to treatment to the mentally retarded as well as the mentally ill, and (4) contained objectively measurable and judicially enforceable standards to allow the implementation of the abstract right to treatment.

The court held that the minimum conditions for any treatment program which would provide adequate[16] treatment were:

(1) individualized treatment plans for all patients;

(2) a humane physical and psychological environment; and

(3) trained and qualified professional and para-professional staff in numbers sufficient to provide adequate treatment.

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[14] Covington v. Harris, 419 F. 2d 617, 623, 624 (D.C. Cir. 1969).

[15] 325 F. Supp 781 (M.D. Ala. 1971) (app. pend Sub. Nom. Aderholt v. Wyatt), 344 F. Supp. 373, 344 F. Supp 387 (M.D. Ala. 1972).

[16] Some courts have been reluctant to apply the "right to treatment" theory because of the difficulty in determining the definition of "adequate treatment", see Burnham v. Department of Pub. Health of State of Ga., 349 F. Supp 1335 (N.D. Georgia, 1972) (app. pend.).

The Burnham decision has been criticized, however, and it has been suggested: "that a reasonable standard for treatment is effectiveness. Treatment is not adequate, or appropriate, or proper, or suitable unless it is effective, or curative, or therapeutic. In other words, treatment cannot meet any minimal standard unless it accomplishes its purpose. The terms are less important than the concept. Treatment, whatever it may be, is undertaken in order to change the behavior which led to the person's confinement." Schwitzgabel, Right to Treatment for the Mentally Disabled: the Need for Realistic Standards and Objective Criteria, Harvard Civil Rights - Civil Liberties Law Review, Vol. 8, No. 3, page 513 at 520. (1973).

The court further specifically ordered what it felt were minimum constitutional standards for adequate treatment of mentally ill,[17] and minimum constitutional standards for adequate habilitation of the mentally retarded.[18] These standards, which include everything from bathroom fixtures to employee-patient ratios, are too lengthy and exhausting to include in this memorandum, however, they should be studied as exemplifying standards which could be applied to Montana's institutions.

Wyatt, of course has by no means clearly established a "right to treatment or habilitation" for mentally handicapped persons involuntarily committed to an institution. The law on this issue is still in a state of flux and Wyatt is a United States District Court decision which has yet to be affirmed by higher courts - quite probably the Supreme Court - before it can be said that the rule and standards in Wyatt are the law of the land.

The Burnham case, mentioned in Note 6, rejected the theory in Wyatt and held that a court was incapable of making the highly technical determinations which a decision on the issues involved required. Another Federal Court in New York St. Ass'n for Retard. Child., Inc. v. Rockefeller,[19] held that, although the " . . . proposition in Rouse that the quid pro quo for commitment in lieu of criminal incarceration must be treatment is not really radical. . . . [e]xpanding that proposition . . . to a constitutional right of habilitation

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[17] Wyatt v. Stickney, 344 F. Supp. 373, 379 (N.D. Ala. 1972).

[18] Wyatt v. Stickney, 344 F. Supp. 387, 395 (N.D. Ala. 1972). Both sets of standards may also be found in the Mental Health Law Project's publication Basic Rights of the Mentally Handicapped, pages 60 through 104, (1973).

[19] 357 F. Supp. 753, 759 (E.D. New York, 1973). Although the Court in this case did not find a "right to habilitation" it did determine that the residents at Willowbrook had a right to protection from assaults by fellow residents and staff, a right to have conditions which violated basic standards of human decency corrected, the right to medical care, the right to an opportunity to exercise and have outdoor recreation, and a number of other constitutional rights the court did not enumerate.

owed by the state . . . to mentally retarded children resident in a state institution . . . is more than the next logical step in an inexorable sequence."

However, another recent case involving the "right to treatment" rejected the notions in the Burnham and New York State Ass'n cases and expounded on Wyatt. This decision, Welsch v. Likens,[20] held that the plaintiffs as a class have a right to adequate care and treatment, that the plaintiffs have the right to the least restrictive practical alternatives to hospitalization, and that the state has an affirmative duty to provide such alternatives.

Some Criticism

The "right to treatment" theory as a judicial remedy has been criticized from several quarters. Some courts have, as indicated above, rejected the doctrine outright. This may well be the result of a reluctance on the part of a court to enter into a highly technical area which, in the court's mind, could be easier handled by the legislature. As a matter of fact, the originator of the theory, Dr. Birnbaum, has stated: "The state legislature rather than the judiciary seems the proper instrumentality to take the lead in establishing and enforcing a right to adequate treatment. Only the legislature has means to set up a comprehensive scheme and to coordinate it with necessary legislative appropriations; the judiciary is limited to a case-by-case development."[21]

Another commentator suggests that as courts develop doctrines such as the "right to treatment" they should remember that legislatures may respond by curtailing services to classes of individuals not constitutionally protected.

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[20] No. 4-72 Civ. 451 (D. Minn) - U.S. Dist. Ct., 4th Div. Minnesota) as yet unreported.

[21] Birnbaum, A Rationale for the Right, 57 Geo. L. J. 752, 765 (1969). It should be noted that this article was written prior to the Wyatt and Welsch decisions as class actions rather than ad hoc individual cases.

"[D]ecisions like Wyatt may have consequences that are neither presently foreseeable nor subject to judicial correction when they finally emerge. Certainly, to the extent that the resources needed to provide constitutionally acceptable treatment for involuntary patients are obtained by limiting existing care and treatment for voluntary patients the result in Wyatt is less than desirable."[22]

Another Problem

The lack of treatment for an individual patient confined pursuant to a civil commitment is also grounds for tort liability by the state or its employees.

In a New York case, Whitree v. State,[23] the plaintiff recovered $300,000 from the state. In that case the court found that the lack of psychiatric treatment was the primary reason for the plaintiff's inordinately long confinement and the resulting effects of physical injury, moral degradation and mental anguish.

In a very recent U.S. District Court case, Donaldson v. O'Connor,[24] the superintendent of the state hospital and a staff psychiatrist were found liable to the plaintiff in the amount of $38,000 - the state was not a party to the action. The court instructed the jury " . . . that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such individual treatment as will give him a realistic opportunity to be cured or to improve his or her mental condition."

The remedy of tort liability is, of course, not foreclosed if the patient is in the institution voluntarily. The state owes that individual such care and treatment as a prudent and reasonable man would expect under similar circumstances.

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[22] Reisner, Psychiatric Hospitalization and the Constitution; Some Observations on Emerging Trends, Law Forum, Vol. 1973, page 9 at 20 (1973).

[23] 290 N.Y.S. 2d 486 (1972)

[24] Civil Action No. 1693 (N.D. Fla., 1972) - As yet unreported.

III. Institutional Peonage - The Right of Compensation for Productive Labor

The term "institutional peonage" has been used to describe the practice of institutions for the mentally handicapped employing residents to perform labor from which the institution derives an economic benefit without adequate compensation. The practice has generally been widespread and has resulted from (1) the need of the institution for the services performed by the resident and (2) the lack of fiscal resources permitting compensation.

The difficulty in distinguishing between work primarily for the benefit of the resident (therapeutic) and work primarily for the benefit of the state has added to the problem of compensation for productive labor.

In the past this issue has been attacked through several different legal approaches. An individual remedy is available each working resident in the form of a private damage action under the Fair Labor Standards Act of 1938 as amended 1966.[25] This federal act establishes minimum wages and overtime compensation for covered employment which includes resident-workers of state institutions.[26]

Another approach is an action for injunctive relief and damages under the Thirteenth Amendment to the United States Constitution claiming that the resident's right to be free from involuntary servitude has been infringed. Not only has this approach been successful in litigation[27] but it has been the basis for an Attorney General's opinion in the state of Washington which has

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[25] 29 U.S.C. §§ 203-219

[26] The United States Department of Labor, as early as 1968, interpreted the 1966 amendments to the FSLA as covering resident-workers, Department of Labor Release G-874, but abstained from enforcement action because of the number of unresolved problems, Department of Labor, Wage and Hour Division, Procedural Instruction, October 13, 1969.

[27] Dale v. State of New York (decided 1973 by State Ct. of Claims, appeal pending).

resulted in action to assure the right to compensation for working residents.[28]

Yet another tactic has been the "right to treatment" approach used in Wyatt v. Stickney.[29] The court, in that case, prohibited uncompensated institution-maintaining labor and adopted standards governing resident labor.

The more successful and most comprehensive approach to this problem, however, has been illustrated by the recent decision of Souder v. Brennan.[30] The plaintiffs in that case asked for injunctive relief against Secretary of Labor Brennan mandating the enforcement of the Fair Labor Standards Act regarding resident-workers in state institutions.

The court determined that the provisions of the Act dealing with employees of non-Federal hospitals and institutions did apply to resident-workers and that the plaintiffs were entitled to injunctive relief. In the words of the court: "Economic reality is the test of employment and the reality is that many of the patient-workers perform work for which they are in no way handicapped and from which the institution derives full economic benefit. So long as the institution derives any consequential economic benefit, the economic reality test would indicate an employment relationship rather than mere therapeutic exercise."[31]

Further, the court emphasized that Section 14 of the Act[32] established a procedure whereby handicapped workers, whose productivity is less than normal, can be certified as such by the Secretary of Labor and paid an appropriate competitive rate for their services.

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[28] See Legal Rights of the Mentally Handicapped, Practising Law Institute, The Mental Health Law Project, (1973, Vol. II, p. 643).

[29] See Part II of this Memorandum - The Right to Treatment.

[30] 367 F. Supp. 808 (1973).

[31] Souder v. Brennan, supra at 813.

[32] 29 U.S.C. § 214, 29 C.F.R. 525.

In addition, Souder was a class action in which the class was defined as all patient-workers in non-Federal institutions for the residential care of the mentally ill and mentally retarded who meet the statutory definition of employee, 29 U.S.C. § 203 (d), (e), (g). This means that each resident in any state institution whose work meets the "economic reality" test is entitled to compensation for that work.[33]

Consistent with this decision, the Department of Labor has announced that it will initiate a vigorous enforcement program beginning December 1, 1974.

IV. The Right to the Least Restrictive Alternative

The right to the least restrictive alternative setting for treatment is an important new emerging right of the mentally handicapped. It has developed as a rough accommodation between constitutionally protected individual liberty and the state's interest in public health, safety, and welfare.

As has been noted in the preceding discussions of the civil commitment process and the right to treatment theory (Parts I and II), several courts have already mandated that the mentally handicapped citizen has a right to the least restrictive practical alternative to hospitalization, and that the state has an affirmative duty to provide such alternatives.[34]

This principle has been articulated by the Supreme Court of the United States thus: " . . . even though the governmental purpose be legitimate and

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[33] The Department of Labor has interpreted this to mean that there is no employment relationship if (1) the tasks performed by the patient are, as a matter of medical judgment, part of a therapeutic or rehabilitative program for the patient, and (2) the patient does not displace a regular employee or impair the employment opportunities of others by performing work which would otherwise be performed by regular employees. Department of Labor Release G-874.

[34] Lessard v. Schmidt, Wyatt v. Stickney, and Welsch v. Likens, all discussed supra.

substantial, that purpose cannot be pursued by means that broadly stifle personal liberties when the end can be more narrowly achieved."[35]

Closely related to this and other rights of the mentally handicapped is the standard which must be applied to justify involuntary commitment of a mentally ill person. The Supreme Court has articulated what has been referred to as the Wisconsin standard which implies the constitutionally proper norm for civil commitment:

> Wisconsin conditions such confinement not solely on the medical judgment that the defendant is mentally ill and treatable, but also on the social and legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty.[36]

It becomes obvious then that an individual may be committed involuntarily only upon a finding by a court that the individual is a danger to himself or others and that there is no other practical alternative to commitment.

I think it safe to conclude that something less than this standard is acceptable regarding the admission of a mentally retarded person to a state institution on the application of a parent or guardian. The level of sophistication of due process of law required in such a situation has not been defined but there are indications that it is lower than that involved in an involuntary civil commitment.[37]

But even though there may be no requirement to prove that the mentally retarded person is a danger to himself or others, the Court still is probably obligated to disallow the admission if there is a practical alternative to confinement.

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[35] Shelton v. Tucker, 364 U.S. 479, 488 (1960). See also page 5 of this memorandum.

[36] Humphrey v. Cady, 405 U.S. 504, 509 (1972)

[37] See page 7 of this memorandum

V. The Status of Legal Rights in Montana

1. Due Process in the Civil Commitment Proceeding.

If the standards of due process of law in an involuntary civil commitment of the mentally ill proceeding adopted by the Court in Lessard v. Schmidt are affirmed by the Supreme Court -- and all indications are that they will be affirmed -- then it will be obvious that the statutory involuntary commitment procedures for the mentally ill in Montana do not afford the subject of a proceeding due process of law.

The statutes in Montana, which provide for the involuntary commitment of a mentally ill person who is a danger to himself or others,[38] besides being very archaic, are deficient in several respects in meeting the standards of due process.

Montana law does not provide for a preliminary hearing within 48 hours of apprehension for the purpose of establishing probable cause for the person's detention. It only provides for a full hearing and it is not specific how soon that hearing must take place to avoid violating the constitutional rights of the alleged mentally ill person. The standard in Lessard was within ten to fourteen days.

Although notice is provided for in our law, it is not specific enough to pass the tests of due process. The state is not required under Montana law to notify the individual with particularity of the basis for his detention. It is not required to inform the subject of his right to counsel or his right to court appointed counsel if he is indigent. There is no provision to inform the alleged mentally ill person of the standard for commitment that the state must meet. The requirement to notify the individual of the names of all the witnesses and doctors who will testify at the hearing is not present. And Montana law does not require that the person be notified of his right to a

[38] Section 38-201, et seq., R.C.M. 1947.

jury trial.[39]

Montana law does not provide for any standard of commitment. Indications are that the constitutional standard required by due process is that the state must prove beyond a reasonable doubt that the subject of the proceeding is mentally ill and that he is a danger to himself or others.

There is no provision for a right to counsel or for court appointed counsel if the person be indigent. Some courts in practice do provide for court appointed counsel if necessary but it should be statutorily specified and applied in all cases.

Montana law also provides for the involuntary commitment of a person who is deemed mentally ill but not considered dangerous.[40] It would seem that, under the "Wisconsin standard"[41] discussed on page 16 of this memorandum, that this provision would be patently unconstitutional.

The statutes in Montana which provide for the voluntary admission of a mentally retarded person to the Boulder River School and Hospital upon the application of the parent guardian or other person with lawful custody of the individual[42] are very similar to the Tennessee laws which were held violative of due process in the Saville v. Treadway case.[43] Some type of a judicial proceeding is required for this type of admission although the level of sophistication of that proceeding has not yet been specified by a court.

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[39]The right to a jury trial is provided for in Section 38-213, R.C.M. 1947. Strange as it may seem, if an alleged mentally ill person asks for a jury trial and is committed by that jury, the Court may assess the costs of the proceeding against him. How ironical it is to require a person to pay the pecuniary costs of losing his liberty.

[40]Sections 38-402 through 38-405, R.C.M. 1947.

[41]The "Wisconsin standard" is dicta of the Supreme Court in the case of Humphrey v. Cady, 405 U.S. 504 (1972).

[42]Sections 80-2304 through 80-2309, R.C.M. 1947

[43]Discussed on page 7 of this memorandum.

2. The Right to Treatment

Recently much controversy has centered around Boulder River School and Hospital and Warm Springs State Hospital regarding the right to treatment of the residents of those institutions.

The U. S. Department of Justice has recently sent a team to the Boulder institution to determine if the patients there have been denied any of their legal rights and, in particular, to appraise the possibility of a "right to treatment" action.

A Montana lawyer-legislator has, in turn, threatened to bring a "right to treatment" case on behalf of the residents of Warm Springs State Hospital, (although, in my opinion, to do so would present him with a conflict of interest until after his term as a state legislator terminates).

I think there is no question that grounds for an action at either institution do exist. As you are aware, there are staffing problems at both institutions and the treatment and habilitation programs are not extensive enough to reach all residents. Some buildings do not lend themselves readily to human occupancy and are in violation of fire, building, and hospital certification regulations, plus they are not Medicaid or Medicare certifiable which results in a loss of revenue to the state.

It is my fear that lawsuits at the present time would be counter-productive. I don't believe an action brought by the U.S. Department of Justice or a private attorney could be properly concluded before the end of the First Regular Session of the Forty-Fourth Legislature. The Legislature would, understandably, be reluctant to take any action on proposed programs and appropriations for the institutions until the litigation was completed and the applicable standards could be ascertained. This would probably force the Legislature into a special session to meet a judicial mandate concerning only those residents whose

constitutional rights have been violated (assuming the case was not appealed, in which case proper legislative action might be postponed until 1976). For this reason, I hope that litigation may be forestalled until such time as the Legislature has had an opportunity to act.

3. The Right to Compensation for Institution-Maintaining Labor.

As stated in Part III, the Department of Labor will institute a vigorous enforcement program December 1 of this year. Federal regulations concerning compensation for resident-workers at the institutions have not yet been issued, but the state should be prepared to be in compliance by that date.

Furthermore, a resident worker has the right to ask for back wages for a period of up to two years, three years if it can be established that the violation was willful.[44] The amount of compensation due resident-workers for back wages may be very hard to establish in many cases because of the lack of adequate work records.

4. The Right to the Least Restrictive Alternative.

In order to protect an individual's right to the least restrictive alternative to institutionalization, it only makes sense that some practical alternatives must exist. Montana is fortunate in this regard because at least the statutory mechanisms are present for viable and effective alternative methods of providing care and treatment for the mentally handicapped.

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[44] 29 U.S.C. 256 (a). The rumor has circulated that the statute of limitations does not apply to residents of state institutions and that they would be entitled to back wages from the time they started work. I contacted the Legal Department of the Denver Office of the U.S. Department of Labor and found this not to be the case.

Concerning the question of whether a violation is willful or not, Courts have taken a new approach. The proposition is that the "Fair Labor Standards Act" has been in existence for a long enough period that if it can be established that an employer knew or suspected that his action might violate the FLSA then it is a willful violation. Coleman v. Jiffy June Farms, Inc., 458 F 2d 1139 (5th Cir. 1971), Brennan v. J.M. Fields, 488 F. 2d 443 (5th Cir. 1974).

In addition to the traditional alternatives, (court-ordered out-patient treatment, day or night hospital treatment, custody by a friend or relative), which are available to both the mentally ill and the mentally retarded a number of other state sponsored programs are available.

Alternatives to involuntary commitment of a mentally ill person to the Warm Springs State Hospital include a provision for the establishment of mental health centers and clinics by the Department of Institutions directly or indirectly by contract or cooperative agreement.[45] Montana law also specifically provides for the establishment and maintenance of Mental Health Centers at Miles City and Glasgow.[46]

There are a number of programs available as possible alternatives to admission of a mentally retarded person to the Boulder River School and Hospital. A mental retardation center has been established and is operating successfully in Glendive.[47] Additional centers similar to this one would not only provide alternatives to institutionalization but would help relieve the resident burden at Boulder.

Several programs have recently been established in the Department of Social and Rehabilitation Services, which, when taken together and are fully operational, will provide an extremely attractive alternative to admission to Boulder. Protective services for the developmentally disabled[48] will provide a variety of services to the mentally retarded person to enable him to more easily live in the community.

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[45]Sections 80-2406 through 80-2411, R.C.M. 1947. Data is presently being compiled by the Department of Institutions on the centers and clinics which are presently operational.

[46]Section 80-2410, R.C.M. 1947.

[47]This center, Eastmont Training Center, was authorized by Section 80-2310, R.C.M. 1947.

[48]Sections 71-1901 through 71-1913, R.C.M. 1947.

Authorization has been given the Department to, either directly or indirectly, establish community homes for the developmentally disabled where the mentally retarded person can receive training and treatment in a family oriented residence.[49]

Although there is no statutory direction to establish them, sheltered workshops, where a mentally retarded person can work and learn, have been established in several communities. They are administered by private boards of directors but the Department has been instrumental in their establishment and initial funding.[50]

In addition, the Legislature has passed the "Developmental Disabilities Services and Facilities Act of 1974" which creates developmentally disability regions in conformance with the Governor's multi-county regions[51] in which the state, in conjunction with regional boards of directors, may provide comprehensive community services for the developmentally disabled including the establishment of clinics or other facilities.[52] Once funding is established at both the local and state levels, this Act should help provide the means to care and treat mentally retarded citizens in the community.

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[49] Sections 71-2001 through 71-2006, R.C.M. 1947. This function was originally delegated to the Department of Institutions in 1973 but was moved to S.R.S. by Ch. 149, Laws of Montana 1974.

[50] In the past S.R.S. has helped support sheltered workshops with federal funds but the Forty Third Legislature, in its Second Regular Session, appropriated $200,000 to the Department to enable it to purchase services from sheltered workshops for severely handicapped persons, H.B. 931.

There are presently five sheltered workshops in Montana. There are also three work activity centers established under the auspices of S.R.S. which provide work activity for mentally retarded persons incapable of productive labor.

[51] Executive Orders 2-71 and 7-73

[52] Sections 80-2611 through 80-2624, R.C.M. 1947.

The fact that some functions relating to the mentally retarded are administered by the Department of Institutions and others are administered by the Department of Social and Rehabilitation Services creates a problem of coordination where those functions overlap or are not complementing each other. There may be a need in the future of direction and coordination of the various programs to insure that the services are provided in the most effective and efficient manner possible.

SENATE BILL 377 (TOWE) - on INVOLUNTARY COMMITMENT.

1. The bill is too long - too involved - too complex; too difficult to follow.

2. It should be 2 rather than 1 bill; one on commitment; and the other on treatment.

3. In the rural areas - which is most of Montana - it would be difficult to impossible to implement. Neither personnel not facilities are available; resources are nil.

4. The bill should call for two - rather than one - examiner. The responsibility for committing anybody is too great to have a single physician carry this load. It is impractical to transport a patient to an inpatient facility for further evaluation on a mandatory basis, when this step could and should have been eliminated by having 2 examiners, and by careful determinations re need for commitment - right from the start. If there is any question re committability after exam. by 2 professionals, it should be resolved by the court, on an optional basis, for an inpatient setting.

5. The 72 hr. evaluation in an inpatient facility is - as a routine measure - too costly, generally unworkable, and antitherapeutic. The general hospitals in rural areas are not equipped or staffed to deal with this type of problem. Since patients are by definition dangerous, it would require special nursing care around the clock for 3 days; it would require a sheriff and an aide to transport the patient - say, to Billings from Richland Co. - if a suitable inpatient facility should be used; then the sheriff would have to go back to Bigs. after 72 hrs. to bring the patient back for a hearing in Sidney. This type of management of a "seriously ill" mental patient is totally anti-therapeutic. The only resource in these rural hospitals is a lock on a door; that and there is. Little can be learned in 72 hrs. which could not have been learned prior

6. The specifications re what types of behavior are committable, are unrealistic. Contrary to general belief, most mental patients are not dangerous or violent. This bill would be highly discriminatory against the bulk of mental patients - who are not violent, and neither are they sufficiently insightful to know that they need care, and therefore are not suitable candidates for Voluntary admission. The image of violence and dangeroushess, which this bill projects, is unfair to mental patients.

7. The bill helps to overload the Court - with routine and unnecessary hearings. Hearing should be available when indicated, but routinely mandated. The fact that these are set up to take precedence over all other business - especially when they are largely form rather than necessary substance, ought to be resisted by the Court.

8. There should have been sufficient clear thinking and evaluation on the part of the 2 examiners and the Court, so that prior to sending the patient to an inpatient facility, it was obvious to all concerned that this was the course to follow. If the commitment forms that would be filled out by these people required answers to such questions as, Do you recommend involuntary commitment? — State your reasons. What benefits would you anticipate through commitment to a hospital that could not be achieved through less restrictive measures? Are there preferable alterbatives to hospitalization available? - then the entire process could be facilitated and the best interests of the patient could be preserved.

9. Mandated and routine hearings for mental patients should have disappeared with the dark ages. It smacks of trials, of criminal proceedings, of being "accused" of being mentally ill - or "charged." If hearings occur, they should not require the presence of the patient, unless the court, having conferred with the examiners, determines that this is the procedure to follow. It is particularly bad to have the patient present if he is in the early stages of an acute psychotic episode - it is antitherapeutic. It is also bad when the patient is paranoid - in which case family or others are very reluctant to present pertinent information lest it ask for later retaliation, or it further disrupt family relations.

10. Again and again the bill seems to assume that the patient is competent. The essence of mental illness is an incompetence in a variety of critical faculties, derived fr faulty perceptions and faulty conclusions. To go ahead as though the patient is com petent when he has been classed as seriously mentally ill, is a mockery.

11. The right to freedom seems to be the only important issue addressed in this Bill. Whereas this right is important, it needs to be seen in perspective - and considering all other needs of the patient which are apparent.

12. When seriously mentally ill patients are not admitted to inpatient care - because they are not dangerous (a la this bill)-they become a menace to family well-being; families caring for them become isolates in their community; visitors are excluded; children, especially, are the victims of the situation, for they are not equipped to know how to throw off the distortions in mentation and behavior that surround them. This bill is unfair to children who come in contact with these people. Mental illness really is "catching" - and this bill insures that it will be spread widely.

13. It wastes scarce - and precious - professional time, running to court and to hearings, and with paper work - to see to it he has met with the meticulous specifications of the law. The section on treatment has been improved through amendments, but it is still far too specific, and obviously, does not comprehend the clinical process. It constantly gets in the way of helping professional people help sick patients.

14. The rights of the patient to dignity and privacy as spelled out in the bill are not functional for mental patients, especially when by definition, all but dangerous patien have been excluded. It asks for suicide. Mental hospitals must be much more non private than general hospitals, because there must be eternal vigilance. This is a factor in making the 72 hr. stay in a hospital unworkable and so costly. Only mental hospitals are prepared to take this kind of care of patients. Keeping track of personal clothing and items would become a costly nightmare when dealing with "serious ill" mental patients - who are confused, or they hoard whatever they get their hand on, or they are destructive. Shutting off the right to inspect mail would be dangerous. Patients not infrequently hide their destructive intentions from staff, but may reveal them in letters, and to cut the professionals off from information of this kind would be highly questionable.

15. The implied costs to the county governments will be a heavy and unreasonable burden Transportation by sheriff's department, hospital evaluations, hearings - even jurisdiction bring up costs - for no gain.

16. Even though Montana needs a new commitment law - which will be reflected in the forms that are to be filled out, - this bill has too many liabilities to warrant support. It is a lawyer's bill; not a bill calculated to help patients get proper care. Both in philosophy and in detail it deserves to be put quietly to rest. There are ways to achieve the goals of this bill (right to freedom, dignity, privacy more realistically - without the costs, the waste of time, the overload on courts, the snowed-up-ness of the evaluation and treatment process implicit in this bill. PLEASE DO NOT SADDLE MONTANA WITH THIS BILL.

Representative Halvorson stated she had just come from the Taxation Committee. Some of these bills have just got to go. She thinks this bill should go into the study on income tax inheritance and so forth. We just can't afford this. Priorities Committee hasn't acted on the request to study inheritance tax yet.

Representative Meloy stated this bill isn't going to do what we think it is going to do, if a study had indicated it would have, he would have no problem of voting in favor of the bill, but would like to feel better about voting this much decrease in revenue.

Representative Moore moved that the bill BE NOT CONCURRED IN. Representative Meloy made a substitute motion that this committee write the Priorities Committee and add our concern to the study of inheritance taxes with emphasis on how it affects rural people and the motion BE NOT CONCURRED IN carried with Representatives Hager, Seifert and Anderson voting no.

SENATE BILL NO. 219 Representative Moore stated there were initially two recodification bills. The first bill prepared is roughly House Bill 183, which wasn't acceptable to members of the legislative committee. The second bill prepared is this one. No appropriation was submitted so we would have to put Representative Bardanouve's bill in this one because of the appropriation. Then the bills could go to a free conference committe Senator Fasbender was agreeable to this.

Representative Moore moved to defer action until tomorrow and he will figure out a way to tie them both togethe The motion to defer action carried.

SENATE BILL NO. 377 Representative Moore moved the bill BE CONCURRED IN. This bill regulates commitment procedures. Extensive disucssion followed by committee members regarding the seventy-two hour evaluation period. Representative Huennekens stated the point of the bill is adequate trial proceeding to protect the rights of the person, the thrust of the bill is to have some legal rights. Representative Moore stated there are counties that clean out their jails around holidays by sending peopl to Warm Springs and that if there is anyplace wnere legal rights are necessary it is with these people. Representative Vincent stated the object of this bill is to protect the rights of a person who may or may not be committed. If you want to make sure individua are protected the process will be more cumbersome.

A substitute motion by Representative Seifert of DO NOT PASS failed on a tie vote with Representatives Huennekens, Moore, Baeth, Lester, Meloy and Vincent voting no, Representative Lory abstaining, and Representatives Kimble, Scully and Yardley absent.

Representative Moore made a substitute motion to defer action on the bill because he missed the hearing and would like to read the bill and give it further thought. The motion carried with Representatives Seifert and Anderson voting no.

SENATE BILL NO. 97 Senator Romney is chief sponsor of this act. Representative Meloy stated that corporations are disallowed under our existing law now. He feels it isn't relevant to discuss the merits of a corporation contributing to a campaign. Representative Rasmussen thinks we should be addressing this question. He feels the bill should be defeated. Considerable discussion followed.

A motion that the bill BE CONCURRED IN carried 7 to 5 with Representatives Anderson, Hager, Lory, Rasmussen and Seifert voting no, Representatives Kimble, Scully and Yardley absent and Representative Halvorson abstaining.

SENATE BILL NO. 348 This is Senator Lynch's bill which was heard today. Representative Anderson moved that the bill BE CONCURRED IN. Chairman Huennekens explained that this bill puts a statute of limitations on collections by the state. The motion BE CONCURRED IN carried with Representative Meloy voting no, Representatives Kimble, Scully and Yardley absent.

The meeting adjourned at 11:55 AM.

HH:pb

Herb Huennekens
REPRESENTATIVE HERB HUENNEKENS
CHAIRMAN

SENATE BILL NO. 250 Representative Meloy proposed several amendments and stated he wants to remove "indecent exposure" from the proposed amendment (see exhibit). He stated the Miller vs. California decision reduces it from the nati al standard to a state standard, all you are doing is conforming existing law to Miller vs. California. Representative Lory sugges adding an effective date of July 1, 1975, and save Missoula from going to court.

Representative Meloy moved to amend his firs amendment by removing "indecent exposure" and as amended moved the amendment to page 4, line 4, by adding a new subsection (5). The motion carried with Representative Rasmussen voting no.

Representative Meloy moved to amend on page line 12, by adding a new subsection (3) as per exhibit. The motic carried unanimously.

Representative Moore moved to strike on page subsection (d) in its entirety and stated that 94-5-504 covers thi in the existing law. Following a discussion by the committee on obscene material, Representative Moore withdrew his motion.

Representative Meloy moved to strike "indece exposure" from the title. The motion carried unanimously with Representatives Kimble, Day, Yardley and Halvorson absent.

Representative Meloy moved to add a section stating the act was effective upon passage and approval. The moti carried with Representative Hager voting no.

The motion that Senate Bill 250 BE CONCURRED IN AS AMENDED carried unanimously. Representatives Kimble, Day, Yardley, Halvorson and Lester were absent.

SENATE BILL NO. 377 Representative Seifert moved BE NOT CONCURRE IN on this measure to revise commitment procedures. A substitute motion of BE CONCURRED IN was made by Representative Moore. Representative Anderson stated he had doubt about this yesterday, no question there are lots of good things in here but it is so detailed. He feels the bill should get to the floor.

Representative Moore stated that he knows fr experience as a public defender that there are some real problems with commitment procedures, he went through Warm Springs at the ti he was a public defender and was advised the greatest abuses occur in involuntary commitments. He feels that the fact that a public defender is there and could oppose makes all the difference in the world. If there wasn't a situation of abuse virtually everything in the bill could be waived. The patient's attorney bill was kill It won't be a difficult or cumbersome procedure. He stated the four-hour limitation is to make sure they don't run the patient through anything too terribly rigorous on the initial examination.

The motion that the bill BE CONCURRED IN carried. On a roll call vote Representatives Day, Hager, Halvorson, Rasmussen, Scully and Seifert voted no, Representative Lory abstained and Representative Vincent was absent. The motion carried 8 to 6.

SENATE BILL NO. 388 Representative Baeth moved BE CONCURRED IN. Representative Moore stated he doesn't think either one of these commitment procedure bills was submitted to snarl up procedure for admitting or treating people. They are here to make sure an individual's legal rights are observed.

Following a very brief discussion, the motion BE CONCURRED IN carried with a 9 to 6 roll call vote. Representatives Day, Hager, Halvorson, Rasmussen, Scully and Seifert voted no. Representative Lory abstained.

SENATE BILL NO. 314 Chairman Huennekens explained that this bill was passed out of committee with a BE NOT CONCURRED IN recommendation. He was asked to reconsider for the purpose of amending the bill and it was moved back into committee. The motion to reconsider carried.

Senator Robert Brown is chief sponsor of this act to provide a cause of action for damages where there has been a violation of rights protected by the Fourth Amendment of the Constitution of the United States and Article II, Section 11 of the Montana Constitution.

Representative Meloy moved to amend page 2, line 2, following the word "prosecution" add", providing;" then add new subsection: "(a) prior to the evidence being secured, a search warrant that was not substantially invalid was issued, and (b) infringement upon individual rights was not substantial." This amendment was prepared by Diana Dowling. Subsection (a) adopts the suggestion of Senator Greely that applies only in cases where search warrants issued, are still excludable. If a search warrant is really a total failure or there are technical violations, then the cause of action could be used against the person. Subsection (b) is taken from the Bivens case and dissent by Burger, looks at the degree of infringement, if blatant they have exclusionary rule. Representative Meloy stated he makes these amendments because he thinks Senator Greely put his finger on the problem but still thinks it is a terrible bill and will vote against it. Representative Rasmussen stated he was opposed to these amendments, they water the bill down.

The motion to amend carried with Representatives Rasmussen and Hager voting no.

Representative Meloy moved BE NOT CONCURRED IN AS AMENDED. Representative Lory made a substitute motion to strike on page 2, subsection (2). He is trying with this amendment to protect the individual. Representative Meloy stated this amendment would completely gut the bill; Representative Moore stated

MR. SPEAKER:

We, your committee on JUDICIARY

having had under consideration SENATE Bill No. 377

A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE FOR DETERMINATION AND TREATMENT OF THE SERIOUSLY MENTALLY ILL AND THOSE SUFFERING FROM MENTAL DISORDERS; AMENDING SECTIONS 38-110, 38-212, 38-506, 38-507, AND ~~80-1801~~ 80-2501; REPEALING SECTIONS 38-107, 38-108, 38-109, 38-112, 38-113, 38-114, 38-115, 38-116, 38-201, 38-202, 38-203, 38-204, 38-205, 38-206, 38-207, 38-208, 38-208.1, 38-208.2, 38-208.3, 38-209, 38-211, 38-213, 38-401, 38-402, 38-403, 38-404, 38-405, 38-406, 38-406.1, 38-406.2, 38-407, 38-408, 38-408.1, 38-502, 38-503, 38-504, 38-505, AND 64-112, R.C.M. 1947."

Respectfully report as follows: That SENATE Bill No. 377

BE CONCURRED IN

HH:pb

STATE PUB. CO.
Helena, Mont.

HERB HUMMERICH, CHAIRMAN Chairman.

SENATE BILL NO. 377

INTRODUCED BY TOWE, DRAKE, ROBERTS, BROWN, SKIBEL, REGAN, FASBENDER, BLAYLOCK, CONOVER, CETRONE, ROMNEY

A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE FOR DETERMINATION AND TREATMENT OF THE SERIOUSLY MENTALLY ILL AND THOSE SUFFERING FROM MENTAL DISORDERS; AMENDING SECTIONS 38-110, 38-212, 38-506, 38-507, AND ~~80-1601~~ 80-2501; REPEALING SECTIONS 38-107, 38-108, 38-109, 38-112, 38-113, 38-114, 38-115, 38-116, 38-201, 38-202, 38-203, 38-204, 38-205, 38-206, 38-207, 38-208, 38-208.1, 38-208.2, 38-208.3, 38-209, 38-211, 38-213, 38-401, 38-402, 38-403, 38-404, 38-405, 38-406, 38-406.1, 38-406.2, 38-407, 38-408, 38-408.1, 38-502, 38-503, 38-504, 38-505, AND 64-112, R.C.M. 1947."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Purpose of act. The purpose of this act is:

(1) to secure for each person who may be seriously mentally ill or suffering from a mental disorder such care and treatment as will be suited to the needs of the person, and to insure that such care and treatment are skillfully and humanely administered with full respect for the person's dignity and personal integrity;

(2) to deprive a person of his liberty for purposes of treatment or care only when less restrictive alternatives are unavailable and only when his safety or the safety of others is endangered, and to provide for due process of law when this is done.

Section 2. Definitions. As used in this act:

(1) "Board" means the mental disabilities board of visitors created by this act.

(2) "Court" means the district court of the state of Montana.

(3) "Department" means the department of institutions.

(4) "Emergency situation" means a situation in which any person is in imminent danger of death or serious bodily harm from the activity of a person who appears to be seriously mentally ill.

(5) "Mental disorder" means any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions.

(6) "Mental health facility" or "facility" means a public hospital or a licensed private hospital or, a community mental health center, or any mental health clinic or treatment center approved by the department. No correctional institution or facility, or jail, is a mental health facility within the meaning of this act.

(7) "Next of kin" shall include, but need not be

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limited to, the spouse, parents, adult children, and adult brothers and sisters of a person.

(8) "Patient" means a person committed by the court to a seventy-two (72) hour evaluation or treatment or for a longer period.

(9) "Peace officer" means any sheriff, deputy sheriff, marshal, policeman or other peace officer.

(10) "Professional person" means:

(a) a medical doctor, or

(b) a person trained in the field of mental health and certified by the ~~regional mental health director if the director is a licensed physician, or by the superintendent of the Montana state hospital, if the superintendent is a licensed physician, in the absence of such a regional director~~ DEPARTMENT OF INSTITUTIONS IN ACCORDANCE WITH STANDARDS OF PROFESSIONAL LICENSING BOARDS, FEDERAL REGULATIONS, AND THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.

(11) "Respondent" means a person alleged in a petition filed pursuant to this act to be seriously mentally ill.

(12) "Responsible person" means any person willing and able to assume responsibility for a seriously mentally ill person, or person alleged to be seriously mentally ill, including next of kin; the person's conservator or legal guardian, if any; representatives of a charitable or

religious organization, or any other person appointed by the court to perform the functions of a "responsible person" set out in this act. Only one person shall at any one time be the "responsible person" within the meaning of this act. In appointing a responsible person, the court shall consider the preference of the respondent. The court may, at any time for good cause shown, change its designation of the "responsible person".

(13) "Seriously mentally ill" means suffering from a mental disorder which has resulted in self-inflicted injury or injury to others, or the imminent threat thereof; or which has deprived the person afflicted of the ability to protect his life or health. No person may be involuntarily committed to a mental health facility not detained for evaluation and treatment because he is an epileptic, mentally deficient, mentally retarded, senile or suffering from a mental disorder unless the condition causes the person to be seriously mentally ill within the meaning of this act.

Section 3. Voluntary ~~commitment~~ ADMISSION -- cost of ~~commitment~~ ADMISSION. (1) Nothing in this act shall be construed in any way as limiting the right of any person to make voluntary application for ~~commitment~~ ADMISSION at any time to any mental health facility or professional person. An application for admission to a mental health facility

shall be in writing on a form prescribed by the facility and approved by the department of institutions. It shall not be valid unless it is approved by a professional person and a copy is given to the person voluntarily ~~committing~~ ADMITTING himself. The form shall contain a statement of the rights of the person voluntarily ~~committing himself~~ APPLYING FOR ADMISSION, as set out in this act, including the right to release.

(2) Any ~~person~~ APPLICANT who wishes to voluntarily ~~commit himself~~ APPLY FOR ADMISSION to the Montana state hospital shall first obtain certification from the regional mental health director of his mental health region or IF NOT REASONABLY AVAILABLE, FROM a professional person ~~designated by the regional director~~ that the ~~person~~ APPLICANT is suffering from a mental disorder and that the facilities available to the mental health region IN WHICH THE APPLICANT RESIDES are unable to provide adequate evaluation and treatment.

(3) An application for voluntary ~~commitment~~ ADMISSION shall give the facility the right to detain the applicant for no more than five (5) days past his written request for release.

(4) The cost of involuntarily committing a patient who is voluntarily ~~committed~~ ADMITTED to a mental health facility at the time the involuntary proceedings are

commenced shall be borne by the county of the patient's residence AT THE TIME OF ADMISSION.

(5) The costs of transportation to a mental health facility under this section shall be provided by the patient, his parents, guardian, or the welfare department of the county of the patient's residence.

(6) Any person voluntarily entering or remaining in any mental health facility shall enjoy all the rights secured to a person involuntarily committed to the facility.

(7) Notwithstanding any other provision of law, a minor who is sixteen (16) years of age or older may consent to receive mental health services to be rendered by a facility or a person licensed to practice medicine or psychology in this state.

(8) VOLUNTARY COMMITMENT OF A MINOR TO A MENTAL HEALTH FACILITY FOR AN IN-PATIENT COURSE OF TREATMENT SHALL BE FOR A PERIOD OF NO MORE THAN THIRTY (30) DAYS. IF THE PROFESSIONAL PERSON IN CHARGE OF A MINOR PATIENT DETERMINES THAT THE COMMITMENT SHOULD CONTINUE FOR A PERIOD OF MORE THAN THIRTY (30) DAYS, HE SHALL COMMENCE INVOLUNTARY COMMITMENT PROCEEDINGS IN ACCORDANCE WITH THIS ACT. COUNSEL SHALL BE APPOINTED FOR THE MINOR.

(9) IF, IN ANY VOLUNTARY COMMITMENT FOR ANY PERIOD OF TIME TO A MENTAL HEALTH FACILITY, A MINOR FAILS TO JOIN IN THE CONSENT OF HIS PARENTS OR GUARDIAN TO THE VOLUNTARY

COMMITMENT, THEN THE COMMITMENT SHALL BE TREATED AS AN INVOLUNTARY COMMITMENT. NOTICE OF THE SUBSTANCE OF THIS SUBSECTION AND OF THE RIGHT TO COUNSEL SHALL BE SET FORTH IN CONSPICUOUS TYPE IN A CONSPICUOUS LOCATION ON ANY FORM OR APPLICATION USED FOR THE VOLUNTARY COMMITMENT OF A MINOR TO A MENTAL HEALTH FACILITY. THE NOTICE SHALL BE EXPLAINED TO THE MINOR BY THE PROFESSIONAL PERSON APPROVING THE APPLICATION.

Section 4. Rights and waiver of rights. (1) Whenever a person is involuntarily detained, or is examined by a professional person pursuant to section 5, or is notified that he will be the subject of a hearing pursuant to section 5 or 6, the person shall be informed of his constitutional rights and his rights under this act. A person may waive his procedural rights, provided that the waiver is knowingly and intentionally made. The right to counsel in a hearing held pursuant to section 6 may not be waived. The right to treatment provided for in this act may not be waived.

(2) In the case of a person who has been ~~committed~~ DETAINED for a seventy-two (72) hour inpatient evaluation and treatment or for a longer period of time, a waiver of rights can be knowingly and intentionally made only with the concurrence of the patient's attorney or of the responsible person appointed by the court. THE RIGHT OF THE RESPONDENT TO BE PHYSICALLY PRESENT AT A HEARING MAY ALSO BE WAIVED BY

HIS ATTORNEY AND THE RESPONSIBLE PERSON WITH THE CONCURRENCE OF THE PROFESSIONAL PERSON AND THE JUDGE UPON A FINDING SUPPORTED BY FACTS THAT:

(A) THE PRESENCE OF THE RESPONDENT AT THE HEARING WOULD BE LIKELY TO SERIOUSLY ADVERSELY AFFECT HIS MENTAL CONDITION, AND

(B) AN ALTERNATIVE LOCATION FOR THE HEARING IN SURROUNDINGS FAMILIAR TO THE RESPONDENT WOULD NOT PREVENT SUCH ADVERSE AFFECTS ON HIS MENTAL CONDITION.

(3) In the case of a minor, the waiver of rights can be knowingly and intentionally made:

(a) when the minor is under the age of twelve (12), by the parents of the minor;

(b) when the minor is over the age of twelve (12), by the youth and his parents;

(c) when the minor is over the age of twelve (12) and the minor and his parents do not agree, the minor can make an effective waiver of his rights only with advice of counsel.

If there is ~~a~~ AN APPARENT conflict of interest between a minor and his parents or guardian, the court may appoint a guardian ad litem for the minor.

(4) In addition to any other rights which may be guaranteed by the constitution of the United States and of this state, by the laws of this state or by this act, any

person who is involuntarily detained or against whom a petition is filed pursuant to this act has the following rights:

(a) the right to notice reasonably in advance of any hearing or other court proceeding concerning him;

(b) the right in any hearing to be present, to offer evidence, and to present witnesses in any proceeding concerning him;

(c) the right in any hearing to cross-examine witnesses;

(d) the right to be represented by counsel;

(e) the right to remain silent;

(f) the right in any hearing to be proceeded against according to the rules of evidence applicable to civil matters generally;

(g) the right to view and copy all petitions on file with the court concerning him;

(h) the right to be examined by a professional person of his choice when such professional person is reasonably available;

(i) the right to be dressed in his own clothes at any hearing held pursuant to this act;

(j) the right to refuse any but lifesaving medication for up to twenty-four (24) hours prior to any hearing held pursuant to this act.

Section 5. Petition alleging person as seriously mentally ill - contents and procedure. (1) A county attorney on his own initiative or upon the request of any person may file a petition with the court alleging that there is a person within the county who is seriously mentally ill and requesting that an evaluation of the person's condition be made.

(2) The petition shall contain:

(a) the name and address of the person requesting the petition and his interest in the case;

(b) the name of the respondent, and, if known, the address, age, sex, marital status, and occupation of the respondent;

(c) the purported facts supporting the allegation of mental illness;

(d) the name and address of every person known or believed to be legally responsible for the care, support, and maintenance of the person for whom evaluation is sought;

(e) the name and address of the person's next of kin, to the extent known to the county attorney and the person requesting the petition;

(f) the name and address of any person whom the county attorney believes might be willing and able to be appointed as responsible person;

(g) the name, address, and telephone number of the

attorney, if any, who has most recently represented the person for whom evaluation is sought. If there is no attorney, there shall be a statement as to whether, to the best knowledge of the person requesting the petition, the person for whom evaluation is sought is indigent and therefore unable to afford the services of an attorney; and

(b) a statement of the rights of the respondent which shall be in conspicuous print and identified by a suitable heading.

(3) Upon presentation to the court by the county attorney, the court shall immediately consider the petition with or without a hearing to determine if there is probable cause to believe that the respondent is seriously mentally ill. If the court finds no such probable cause, the petition shall be discharged. If the court finds probable cause it shall submit the petition to a professional person for evaluation. If probable cause is found, the court may appoint a responsible person to protect the interests of the respondent. The responsible person shall be notified as soon as possible that a petition has been filed. Notice of the petition and the finding of probable cause shall be hand delivered or mailed to the respondent and to the attorney, the person or persons legally responsible for care, support, and maintenance of the respondent, next of kin identified in the petition, and the person or persons identified by the

county attorney as possible responsible persons.

(4) (a) Upon receipt of the petition, the professional person shall examine the respondent and make such inquiry as he or she may deem appropriate. If the respondent does not cooperate and if requested by the professional person, the court may order the respondent to submit to examination by a professional person at a time and place designated by the court. The examination so ordered shall not exceed a period of four (4) hours.

(b) When the professional person first contacts the respondent, before he begins any examination, he shall give a copy of the petition to the respondent, and shall explain to the respondent the nature of the proceeding and his rights as set forth in the petition.

(5) On the basis of his examination, the professional person shall recommend in writing either that the petition be dismissed or that a seventy-two (72) hour inpatient evaluation and treatment be ordered. If dismissal is recommended, the petition shall be summarily dismissed. The petition shall be dismissed if the respondent accepts voluntary treatment or ~~commitment~~ ADMISSION to a mental health facility approved by the professional person conducting the examination. Whenever a professional person recommends that a seventy-two (72) hour evaluation and treatment be ordered, the recommendation shall be

accompanied by a report explaining the reason for the recommendation and identifying any tests or evaluation devices which the professional person employed in evaluating the respondent. If the professional person recommends that a seventy-two (72) hour evaluation and treatment be ordered, notice of this recommendation shall be mailed or delivered to the respondent, the next of kin, when known, any person responsible for the care, support, and maintenance of the respondent, any other person identified in the petition, and the responsible person, if any, appointed by the court. Notice shall include the date, time, and place of the respondent's next appearance before the court.

(6) In the event the examining professional person recommends a seventy-two (72) hour inpatient evaluation and treatment, the respondent shall be brought before the court by the county attorney without undue delay, advised of the recommendation, supplied with a copy of the petition and the recommendation and advised of his rights to a hearing and to counsel. If a responsible person has not yet been appointed, the court shall appoint a responsible person at this time. If the right to a hearing and to counsel are waived, the court shall direct that the respondent be detained at a mental health facility for evaluation and treatment not to exceed seventy-two (72) hours. If a hearing is requested by the respondent, his attorney, or the

responsible person appointed by the court, a time and place shall be set for the hearing. The matter shall be given precedence over all other court matters. If the respondent is unwilling or unable to retain counsel, the court shall appoint counsel and be responsible for notification.

(7) The hearing shall be held before the court without a jury. The respondent may present such testimony and relevant documentary evidence as he or the responsible person or counsel desires. The county attorney shall represent the state. The professional person who made the recommendation shall be present in court and may be cross-examined concerning his recommendation and his report. After full hearing the court shall determine whether the respondent is seriously mentally ill within the definition provided herein. If the court finds the respondent is not seriously mentally ill, he or she shall be discharged and the petition dismissed. If the court finds the respondent to be seriously mentally ill, it shall order the respondent detained at a mental health facility for examination and treatment not exceeding seventy-two (72) hours. However, the court may dismiss the petition if the respondent agrees to accept voluntary treatment or ~~commitment~~ ADMISSION to a mental health facility.

(8) Persons receiving evaluation and treatment pursuant to this section shall be given a reasonable choice

of an available professional person qualified to provide such services.

Section 6. Petition for commitment — trial — determination of court. (1) If in the opinion of the professional person in charge of the patient the person detained under the provisions of section 5 of this act does not require further evaluation or treatment he shall be released within seventy-two (72) hours. If, in the opinion of the professional person, the patient requires further evaluation or treatment, he shall advise the court accordingly not less than three (3) days from the date of detention and shall within the same time file a petition requesting that the patient be committed to a facility for a period not in excess of three (3) months. The petition shall be accompanied by a written report and evaluation of the patient's mental and physical condition. The report shall explain the reasons for the petition and shall identify any tests or evaluation devices which the professional person employed in evaluating the patient. The professional person may retain THE PATIENT IN custody ~~of the patient~~ BY COURT ORDER pending a hearing on the petition only if detention is necessary to prevent injury to ~~himself~~ THE PATIENT or others.

(2) Upon receipt of a petition for commitment not to exceed three (3) months, the court shall immediately set the

time and place for a hearing, which shall be held not more than three (3) days from the receipt of the petition. The court may extend the period to seven (7) days. The time for the hearing may be further extended at the request of counsel for the patient. The court shall give written notice to the professional person who requested the commitment, the patient, his counsel, his next of kin, when known, the responsible person appointed by the court, and the county attorney. At any time prior to the date set for hearing, the patient, or his attorney, may request a jury trial, whereupon the time set for hearing will be vacated and the matter set on the court's jury calendar at the earliest date possible, the matter taking precedence over all other matters on the jury calendar.

(3) At any time prior to trial on the petition before court or jury, the patient may waive trial and give written consent to commitment to a facility for a period not to exceed three (3) months. Such consent must be joined in writing, by his attorney and by the responsible person appointed by the court.

(4) The patient shall be present and represented by counsel at all stages of the trial, and the sole question to be determined by the court or jury, as the case may be, shall be whether the patient is seriously mentally ill within the meaning set forth in this act. The professional

person who filed the petition shall be present in court for the hearing and subject to cross-examination. The trial shall be governed by the Montana rules of civil procedure except that, if tried by a jury, at least three-fourths (3/4) of the jurors must concur on a finding that the patient is seriously mentally ill. The finding may be appealed to the Montana supreme court in the same manner as other civil matters. The standard of proof in any hearing held pursuant to this section shall be proof beyond a reasonable doubt. ANY COURT MAY ORDER A HEARING CLOSED TO THE PUBLIC FOR THE PROTECTION OF THE RESPONDENT.

(5) If, upon hearing, it is determined that the patient is not seriously mentally ill within the meaning of this act, he shall be discharged and the petition of the professional person dismissed. If it is determined that the patient is seriously mentally ill within the meaning of this act the court shall:

(a) commit the patient to a facility for a period of not more than three (3) months;

(b) order the patient to be placed in the care and custody of his relative or guardian or some other appropriate place other than an institution;

(c) order outpatient therapy; or

(d) make some other appropriate order for treatment.

No treatment ordered pursuant to this subsection shall

affect the patient's custody for a period of more than three (3) months.

In determining which of the above alternatives to order, the court shall choose the least restrictive alternatives necessary to protect the patient and the public and to permit effective treatment. The court shall consider and shall describe in its order what alternatives for treatment of the patient are available, what alternatives were investigated and why the investigated alternatives were not deemed suitable. THE COURT SHALL ENTER INTO THE RECORD A DETAILED STATEMENT OF THE FACTS UPON WHICH IT FOUND THE RESPONDENT TO BE SERIOUSLY MENTALLY ILL.

At any time within the three (3) month period the patient may be discharged on the written order of the professional person in charge of the patient. In the event the patient is not discharged within the three (3) month period and if the term is not extended as provided herein, the patient ~~will~~ SHALL be discharged by the facility at the end of three (3) months without further order of the court. Notice of such discharge will be filed with the court within five (5) days of the discharge.

(6) Not less than two (2) calendar weeks prior to the end of the three (3) month period of detention, the professional person in charge of the patient may petition the court for extension of the detention period. The

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petition shall be accompanied by a written report and evaluation of the patient's mental and physical condition. The report shall describe any tests and evaluation devices which have been employed in evaluating the patient, the course of treatment which has been undertaken for the patient and the future course of treatment anticipated by the professional person. Upon the filing of the petition, the court shall give written notice of the filing of the petition to the patient, his next of kin, if reasonably available, the responsible person appointed by the court, and to the patient's counsel. If any person so notified requests a hearing prior to the termination of the previous detention authority the court shall immediately set a time and place for such a hearing on a date not more than ten (10) days from the receipt of the request and notify the same people including the professional person in charge of the patient. Procedure on the petition for extension shall be the same in all respects, as the procedure on the petition for the original three (3) month commitment ~~save and except~~ the patient shall not be entitled to trial by jury. The hearing shall be held in the district court having jurisdiction over the facility in which the patient is detained unless otherwise ordered by the court. If upon the hearing the court finds the patient ~~to be~~ not seriously mentally ill within the meaning of this act, the patient

shall be discharged and the petition dismissed. If the court finds that the patient continues to suffer from ~~such~~ serious mental illness, the court shall order commitment, custody in relatives, outpatient therapy or other order as set forth in subsection (5) of this section except that no order shall affect his custody for more than six (6) months. In its order, the court shall describe what alternatives for treatment of the patient are available, what alternatives were investigated, and why the investigated alternatives were not deemed suitable. The court shall not order continuation of an alternative which does not include a comprehensive, individualized plan of treatment for the patient. Any court order for the continuation of an alternative shall include a specific finding that a comprehensive, individualized plan of treatment exists.

(7) Further extensions may be obtained under the same procedure described in subsection (6) of this section except that the patient's custody shall not be affected for more than one (1) year, without a renewal of the commitment under the procedures set forth in subsection (6) of this section, including a statement of the findings required by subsection (8).

(8) At any time during the patient's commitment the court may on its own initiative or upon application of the professional person in charge of the patient, the patient,

his next of kin, his attorney, or the responsible person appointed by the court, order the patient to be placed in the care and custody of relatives or guardians, or to be provided outpatient therapy or other appropriate placement or treatment.

Section 7. Emergency situation — petition — detention. (1) When an emergency situation exists, a peace officer may take any person who appears to be seriously mentally ill and, as a result of serious mental illness, to be a danger to others or to himself into custody only for sufficient time to contact a professional person for emergency evaluation. If possible, a professional person should be called prior to taking the person into custody.

(2) If the professional person agrees that the person detained appears to be seriously mentally ill and that an emergency situation genuinely exists, then the person may be detained until the next regular business day. At that time, the professional person shall either cause the county attorney to file the petition provided for in section 5 of this act or shall release the detained person. In either case, the professional person shall file a report with the court explaining his actions.

(3) When the petition is filed, after an emergency detention, the court may order the respondent detained for the amount of time necessary for a professional person to

conduct the examination and inquiry provided for in section 5 and to report his findings and recommendations to the court. In no case shall such detention exceed twenty-four (24) hours from the time of the filing of the petition. Saturday, Sunday, and legal holidays shall not be included in computing the twenty-four (24) hour period. The court may also order the respondent detained during the seventy-two (72) hour evaluation and treatment period, if ordered, and through the period of the hearing on initial commitment, if held. No period of detention shall be ordered by the court pursuant to this section unless the court finds that such detention is required in the interest of public safety <u>OR THE LIFE OR SAFETY OF THE RESPONDENT</u>. An order of detention shall include a statement of the factual basis for the order.

(4) Any person detained pursuant to this section shall be detained in the least restrictive environment required to protect the life and physical safety of the person detained or of members of the public. Whenever possible, a person detained pursuant to this section shall be detained in a mental health facility. A person may be detained in a jail or other correctional facility only if no mental health facility is available or if the available mental health facilities are inadequate to protect the person detained and the public. As soon as a mental health facility becomes

available or the situation has changed sufficiently that an available mental health facility is adequate for the protection of the person detained and of the public, then the detained person shall be transferred from the jail or correctional facility to the mental health facility. In no case shall a person be detained in a jail or other correctional facility pursuant to this section for a longer period of time than is required for the county attorney to file a petition and for a professional person to complete his initial examination and inquiry and report his findings to the court.

(5) The county attorney of any county may make arrangements with any federal, state, regional, or private mental facility or with a mental health facility in any county for the detention of persons held pursuant to this section.

Section 8. Outpatient care — conditional release. (1) When in the opinion of the professional person in charge of a mental health facility providing involuntary treatment, the committed person can be appropriately served by outpatient care prior to the expiration of the period of commitment, then such outpatient care may be required as a condition for early release for a period which, when added to the inpatient treatment period, shall not exceed the period of commitment. If the mental health facility

designated to provide outpatient care is other than the facility providing involuntary treatment, the outpatient facility so designated must agree in writing to assume such responsibility.

(2) The mental health facility designated to provide outpatient care or the professional person in charge of the patient's case may modify the conditions for continued release when such modification is in the best interest of the patient.

(3) If the mental health facility designated to provide outpatient care determines that a conditionally released person is failing to adhere to the terms and conditions of his release, and because of that failure has become a substantial danger to himself or other persons, then, upon notification by the mental health facility designated to provide outpatient care, or on his own motion, the professional person in charge of the patient's case may order that the conditionally released person be apprehended and ~~taken into custody and temporarily detained in a mental health facility in or near the county in which he is receiving outpatient treatment until such time, not exceeding five (5) days, as a hearing can be scheduled to determine whether or not the person should be returned to the mental health facility from which he had been~~ RETURNED TO THE FACILITY FROM WHICH HE WAS conditionally released.

The professional person in charge of the patient's case may modify or rescind such order at any time. ~~prior to commencement of the court hearing. The court shall be notified before the close of the next judicial day of a person's detention under the provisions of this section, and the county attorney of the county where the patient is receiving outpatient treatment shall file a petition and order of apprehension and detention with the court and~~ THE PROFESSIONAL PERSON SHALL mail or deliver notice to the person detained, his attorney, if any, and his guardian or conservator, if any, his next of kin, if known, and the responsible person appointed by the court. ~~Such person shall have the same rights with respect to notice, hearing, and counsel as for an involuntary commitment proceeding, except as specifically set forth in this section and except that there shall be no right to jury trial. The issues to be determined shall be whether the conditionally released person did or did not adhere to the terms and conditions of his release; and, if he failed to adhere to such terms and conditions, (a) whether he is likely to injure himself or other persons if not returned for involuntary treatment on an inpatient basis, or (b) whether the conditions of release should be modified. Pursuant to the determination of the court upon such hearing, the conditionally released person shall either continue to be conditionally released on the same or modified conditions or shall be returned for involuntary treatment on an inpatient basis subject to release at the end of the period for which he was committed for involuntary treatment, or otherwise in accordance with the provisions of this act. Such hearing may be waived by the person and his counsel and the responsible person, but shall not be waivable unless all such persons agree to waive, and upon such waiver the person may be returned for involuntary treatment or continued on conditional release on the same or modified conditions.~~

(4) The proceedings set forth in subsection (3) of this section may be initiated by the professional person in charge of the patient's case on the same basis set forth therein without the professional person requiring or ordering the apprehension and detention of the conditionally released person. ~~, in which case the court hearing shall take place in not less than fifteen (15) days from the date of service of the petition upon the conditionally released person.~~

Upon expiration of the period of commitment, or when the ~~person~~ PATIENT is released from outpatient care, notice in writing to the court which committed the ~~person~~ PATIENT for treatment shall be provided BY THE PROFESSIONAL PERSON IN CHARGE OF THE PATIENT.

Section 9. Right to counsel and appeal — examination

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of respondent — records. (1) The person alleged to be seriously mentally ill shall HAVE THE RIGHT TO be present at any hearing or trial. If he has no attorney, the judge shall appoint an attorney to represent him at either the hearing or the trial or both. If the court determines that the respondent is financially unable to employ an attorney, the court shall appoint counsel who shall be compensated from the public funds of the county where the respondent resides. The county of residence shall also pay all precommitment expenses including transportation to a mental health facility incurred in connection with the ~~arrest~~ DETENTION, examination, and precommitment custody OF THE RESPONDENT.

(2) The respondent, his attorney, or the responsible person appointed by the court may secure a professional person of his own choice to examine the respondent and to testify at the hearing before the court or jury as to the results of his examination.

(3) If the person wishing to secure the testimony of a professional person is unable to do so because of financial reasons, and if the respondent joins in the request for such examination, the court shall appoint a professional person other than the professional person requesting the commitment to perform the examination. Whenever possible, the court shall allow the respondent a reasonable choice of an

available professional person qualified to perform the requested examination WHO WILL BE COMPENSATED FROM THE PUBLIC FUNDS OF THE COUNTY WHERE THE RESPONDENT RESIDES.

(4) Every respondent subject to an order for short-term treatment or long-term care and treatment shall be advised of his right to appeal such order by the court at the conclusion of any hearing as a result of which such an order may be entered.

(5) Records and papers in proceedings under this act shall be maintained separately by the clerks of the several courts. Upon the release of any respondent or patient, the facility shall notify the clerk of the court within five (5) days of the release, and the clerk shall immediately seal the record in the case and omit the name of the respondent or patient from the index or indices of cases in such court ~~until and~~ unless the court orders ~~her~~ THE RECORD opened for good cause shown.

Section 10. Transfer or commitment to facility — procedure. No person who is in the custody of the department of institutions for any purpose other than treatment of severe mental illness shall be transferred or committed to a mental health facility unless such transfer or commitment is effected according to the procedures set out in this act.

Section 11. Appeal procedure. Appellate review of any

order of short-term EVALUATION AND treatment or long-term ~~care and treatment~~ COMMITMENT may be had by appeal to the supreme court of Montana in the manner as other civil cases. The patient shall not be released pending appeal unless ordered by the court. The appeal shall have priority above all other matters before the supreme court.

Section 12. Effect of act on persons currently judged mentally ill. Any person who, by reason of a judicial decree entered by a court of this state prior to the enactment of this act adjudicating such person mentally ill shall, one (1) year following the effective date of this act be deemed to have been released and restored to legal capacity and competency unless, before that time, a petition for an extended detention order is filed with the court.

Section 13. Civil and legal rights of person committed. (1) Unless specifically stated in an order by the court, a person involuntarily committed to a facility for a period of evaluation or treatment shall not forfeit any legal right or suffer any legal disability by reason of the provisions of this act except insofar as it may be necessary to detain the person for treatment, evaluation or care.

(2) Whenever any person is committed to a mental health facility for a period of three (3) months or longer, the court ordering the commitment may make an order stating

specifically any legal rights which are denied the respondent and any legal disabilities which are imposed on him. As part of its order, the court may appoint a person to act as conservator of the respondent's property. Any conservatorship created pursuant to this section shall terminate upon the conclusion of the involuntary commitment if not sooner terminated by the court. A conservatorship or guardianship extending beyond the period of involuntary commitment may not be created except according to the procedures set forth under Montana law for the appointment of conservators and guardians generally.

(3) Any person who has been committed to a mental health facility pursuant to this act shall be automatically restored upon the termination of the commitment to all of his civil and legal rights which may have been lost when he was committed. This subsection shall not affect, however, any guardianship or conservatorship created independently of the commitment proceedings, according to the provisions of Montana law relating to the appointment of conservators and guardians generally. Any person who leaves a mental health facility following a period of evaluation and treatment shall be given a written statement setting forth the substance of this subsection.

(4) Any person committed to a mental health facility prior to the effective date of this act shall enjoy all the

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rights and privileges of a person committed after the effective date of this act.

(5) No person who has received evaluation or treatment under any provisions of this act shall be discriminated against because of such status. For purposes of this section, "discrimination" means giving any unfavorable weight to the fact of hospitalization or outpatient care and treatment unrelated to a person's present capacity to meet standards applicable to all persons. The fact that a person has received evaluation and treatment, whether voluntarily or involuntarily, at any mental health facility shall not be admitted into evidence in any subsequent proceeding for involuntary commitment or for the appointment of a guardian or conservator.

Section 14. Transfer of person committed. (1) If a person is committed under the provisions of this act and is eligible for hospital care or treatment by an agency of the United States, and if a certificate of notification from such agency showing that facilities are available and that the person is eligible for care or treatment therein is received, the court may order the person to be placed in the custody of the agency for hospitalization. The chief officer of any hospital or institution operated by such an agency and in which a person is so hospitalized shall be vested with the same powers as the superintendent of the

Montana state hospital with respect to detention, custody, transfer, conditional release, or discharge of the person. Jurisdiction shall be retained in the appropriate courts of this state to inquire into the mental condition of persons so hospitalized, and to determine the necessity for continuance of their hospitalization.

(2) Consistent with other provisions of this act, a person committed under this act for a period of three (3) months or longer may be committed by the court to the custody of friends or next of kin residing outside the state or to a mental health facility located outside the state, if the out-of-state facility agrees to receive the patient, provided, however, that no such commitment shall be for a longer period of time than is permitted within the state. If the patient is indigent, the expense of supporting him in an out-of-state facility and the expense of transportation shall be borne by the state of Montana.

(3) The transfer of persons committed under the provisions of this act out of Montana or under the laws of another jurisdiction into Montana shall be governed by the provisions of the interstate compact on mental health.

Section 15. Fingerprinting prohibited. No person admitted to or in a mental health facility shall be fingerprinted unless required by other provisions of law.

Section 16. Photographs permitted — confidential.

(1) A person admitted to a mental health facility may be photographed upon admission for identification and the administrative purposes of the facility. Such photographs shall be confidential and shall not be released by the facility except pursuant to court order.

(2) No other nonmedical photographs shall be taken or used without consent of the patient's legal guardian or the responsible person appointed by the court.

Section 17. Rights of persons admitted to facility. Patients admitted to a mental health facility, whether voluntarily or involuntarily, shall have the following rights:

(1) Patients have a right to privacy and dignity.

(2) Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment.

(3) Patients shall have the same rights to visitation and reasonable access to private telephone communications as patients at any public hospitals, except to the extent that the professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued. Patients shall have an unrestricted right to visitation with attorneys, with spiritual counsellors, and with private physicians and other

professional persons.

(4) Patients shall have an unrestricted right to send sealed mail. Patients shall have an unrestricted right to receive sealed mail from their attorneys, private physicians, and other professional persons, from the mental disabilities board of visitors, from courts, and government officials. Patients shall have a right to receive sealed mail from others, except to the extent that a professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions on receipt of sealed mail. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued.

(5) Patients have an unrestricted right to have access to letter writing materials, including postage, and have a right to have staff members of the facility assist persons who are unable to write, prepare, and mail correspondence.

(6) Patients have a right to wear their own clothes and to keep and use their own personal possessions including toilet articles, except insofar as such clothes or personal possessions may be determined by a professional person in charge of the patient's treatment plan to be dangerous or otherwise inappropriate to the treatment regimen. The facility has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable

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clothing of their own. Patients shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the patient's throughout his stay at the facility. The facility shall make provision for the laundering of patient clothing.

(7) Patients have the right to keep and be allowed to spend a reasonable sum of their own money.

(8) Patients have the right to religious worship. Provisions for such worship shall be made available to all patients on a nondiscriminatory basis. No individual shall be required to engage in any religious activities.

(9) Patients have a right to regular physical exercise several times a week. Moreover, it shall be the duty of the facility to provide facilities and equipment for such exercise. Patients have a right to be outdoors at regular and frequent intervals, in the absence of CONTRARY medical considerations.

(10) Patients have the right to be provided with adequate supervision, suitable opportunities for interaction with members of the opposite sex, except to the extent that a professional person in charge of the patient's treatment plan writes an order stating that such interaction is inappropriate to the treatment regimen.

(11) Patients have a right to receive prompt and adequate medical treatment for any physical ailments. In

providing medical care, the mental health facility shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the patient's treatment for mental illness with his medical treatment.

(12) Patients have a right to a diet that will provide at a minimum the recommended daily dietary allowances as developed by the national academy of sciences. Provisions shall be made for special therapeutic diets and for substitutes at the request of the patient, or the responsible person, in accordance with the religious requirements of any patient's faith. Denial of a nutritionally adequate diet shall not be used as punishment.

(13) Patients have a right to a humane psychological and physical environment within the mental health facilities. These facilities shall be designed to afford patients with comfort and safety, promote dignity, and ensure privacy. The facilities shall be designed to make a positive contribution to the efficient attainment of the treatment goals set for the patient. In order to assure the accomplishment of this goal:

(a) Regular housekeeping and maintenance procedures which will ensure that the facility is maintained in a safe, clean, and attractive condition shall be developed and implemented.

(b) There must be special provision made for geriatric

and other nonambulatory patients to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory patients to communicate their needs to the facility staff.

(c) Pursuant to an established routine maintenance and repair program, the physical plant of every facility shall be kept in a continuous state of good repair and operation in accordance with the needs of the health, comfort, safety, and well-being of the patients.

(d) Every facility must meet all fire and safety standards established by the state and locality. In addition, any hospital shall meet such provisions of the Life Safety Code of the national fire protection association as are applicable to hospitals. Any hospital shall meet all standards established by the state for general hospitals, insofar as they are relevant to psychiatric facilities.

Section 18. Patient labor — rules. The following rules shall govern patient labor:

(1) No patient shall be required to perform labor which involves the operation and maintenance of a facility or for which the facility is under contract with an outside organization. Privileges or release from the facility shall not be conditioned upon the performance of labor covered by this provision. Patients may voluntarily engage in such

labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. sec. 206 as amended.

(2) (a) Patients may be required to perform therapeutic tasks which do not involve the operation and maintenance of the facility, provided the specific task or any change in assignment is:

(i) An integrated part of the patient's treatment plan and approved as a therapeutic activity by a professional person responsible for supervising the patient's treatment; and

(ii) Supervised by a staff member to oversee the therapeutic aspects of the activity.

(b) Patients may voluntarily engage in therapeutic labor for which the facility would otherwise have to pay an employee, provided the specific labor or any change in labor assignment is:

(i) An integrated part of the patient's treatment plan and approved as a therapeutic activity by a professional person responsible for supervising the patient's treatment; and

(ii) Supervised by a staff member to oversee the therapeutic aspects of the activity; and

(iii) Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. sec. 206 as

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amended.

(3) If any patient performs therapeutic labor which involves the operation and maintenance of a facility, but due to physical or mental disability is unable to perform the labor as efficiently as a person not so physically or mentally disabled, then the patient may be compensated at a rate which bears the same approximate relation to the statutory minimum wage as his ability to perform that particular job bears to the ability of a person not so afflicted.

(4) Patients may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.

(5) ~~Patients shall be allowed to use~~ DEDUCTIONS OR PAYMENTS FOR CARE AND OTHER CHARGES SHALL NOT DEPRIVE A PATIENT OF a reasonable amount of the compensation received pursuant to this section for personal and incidental purchases and expenses.

Section 19. Medication for patients. Patients have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. ~~The professional person in charge of the facility and the~~ THE attending physician shall be responsible for all medication given or administered to a patient. The use of medication shall not exceed standards

of use that are advocated by the United States food and drug administration. Notation of each individual's medication shall be kept in his medical records. At least weekly an attending physician shall review the drug regimen of each patient under his care. ~~All~~ EXCEPT IN THE CASE OF OUTPATIENTS, ALL prescriptions shall be written with a termination date, which shall not exceed thirty (30) days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for A TREATMENT program, or in quantities that interfere with the patient's treatment program.

Section 20. Physical restraint and isolation. Patients have a right to be free from physical restraint and isolation. Except for emergency situations, in which it is likely that patients could harm themselves or others and in which less restrictive means of restraint are not feasible, patients may be physically restrained or placed in isolation only on a professional person's written order which explains the rationale for such action. The written order may be entered only after the professional person has personally seen the patient concerned and evaluated whatever episode or situation is said to call for restraint or isolation. Emergency use of restraints or isolation shall be for no more than one (1) hour, by which time a professional person shall have been consulted and shall have entered an

appropriate order in writing. Such written order shall be effective for no more than twenty-four (24) hours and must be renewed if restraint and isolation are to be continued. Whenever a patient is subject to restraint or isolation, adequate care shall be taken to monitor his physical and psychiatric condition and to provide for his physical needs and comfort.

Section 21. Research on patients — restrictions. Patients shall have a right not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give such consent, and of his guardian, if any, and the responsible person appointed by the court, after opportunities for consultation with independent specialists and with legal counsel. If there is no responsible person or if the responsible person appointed by the court is no longer available, then a responsible person who is in no way connected with the facility, the department of institutions, or the research project shall be appointed prior to the involvement of the patient in any experimental research. The facility shall send notice of intent to involve the patient in experimental research to the patient, his next of kin, if known, his legal guardian, if any, the attorney who most recently represented him, and the responsible person appointed by the court at least ten (10) days prior to the

commencement of such experimental research.

Such proposed research shall first have been reviewed and approved by the mental disabilities board of visitors before such consent shall be sought. Prior to such approval the board shall determine that such research complies with the principles of the statement on the use of human subjects for research of the American association on mental deficiency and with the principles for research involving human subjects required by the United States department of health, education, and welfare for projects supported by that agency.

Section 22. Treatment procedures — restrictions. Patients have a right not to be subjected to treatment procedures such as lobotomy, ~~electro-convulsive treatment,~~ adversive reinforcement conditioning, or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel, the legal guardian, if any, the responsible person appointed by the court, and any other interested party of the patient's choice. At least one (1) of those consulted must consent to the treatment. If there is no responsible person or if the responsible person appointed by the court is no longer available, then a responsible person who is in no way connected with the facility or with the department of institutions shall be appointed before any such treatment

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procedure can be employed. The facility shall send notice of intent to employ extraordinary treatment procedures to the patient, his next of kin, if known, the legal guardian, if any, the attorney who most recently represented him and the responsible person appointed by the court at least ten (10) days prior to the commencement of such extraordinary treatment program.

Section 23. Professional person — qualifications. In every mental health facility to which a person is admitted pursuant to this act:

(1) Each professional person AND OTHER STAFF MEMBER employed by the facility shall meet all ~~licensing and~~ certification requirements promulgated by the ~~state of Montana for persons engaged in private practice of the same profession elsewhere in Montana~~ DEPARTMENT OF INSTITUTIONS. ~~Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their specialty elsewhere in Montana.~~

(2) All nonprofessional staff members who have not had prior clinical experience in a mental institution shall have a substantial orientation training.

(3) Staff members on all levels shall have regularly scheduled in-service training.

(4) Each nonprofessional staff member shall be under the direct supervision of a professional person.

Section 24. Treatment plan for patient established. (1) Each patient admitted AS AN INPATIENT to a mental health facility for a period of more than seventy-two (72) hours shall have a comprehensive physical and mental examination and review of behavioral status within forty-eight (48) hours after admission to the mental health facility.

(2) Each patient shall have an individualized treatment plan. This plan shall be developed by appropriate professional persons including a psychiatrist, IF REASONABLY AVAILABLE and implemented as soon as possible, in any event, no later than five (5) days after the patient's admission. Each individualized treatment plan shall contain:

(a) a statement of the nature of the specific problems and specific needs of the patient;

(b) a statement of the least restrictive treatment conditions necessary to achieve the purposes of commitment;

(c) a description of intermediate and long-range treatment goals, with a projected timetable for their attainment;

(d) a statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

(e) a specification of staff responsibility and a description of proposed staff involvement with the patient

in order to attain these treatment goals;

(f) criteria for release to less restrictive treatment conditions, and criteria for discharge;

(g) a notation of any therapeutic tasks and labor to be performed by the patient.

(3) As part of his treatment plan, each patient shall have an individualized after care plan. This plan shall be developed by a professional person as soon as practicable after the patient's admission to the facility.

(4) In the interests of continuity of care, whenever possible, one professional person (who need not have been involved with the development of the treatment plan) shall be responsible for supervising the implementation of the treatment plan, integrating the various aspects of the treatment program and recording the patient's progress. This professional person shall also be responsible for ensuring that the patient is released, where appropriate, into a less restrictive form of treatment.

(5) The treatment plan shall be continuously reviewed by the professional person responsible for supervising the implementation of the plan and shall be modified if necessary. Moreover, at least every ninety (90) days, each patient shall receive a mental examination from, and his treatment plan shall be reviewed by, a professional person other than the professional person responsible for

supervising the implementation of the plan.

Section 25. Examination following commitment. No later than fifteen (15) days after a patient is committed to a mental health facility, the professional person in charge of the facility, or his appointed, professionally qualified agent, shall examine the committed patient and shall determine whether the patient continues to require commitment to the facility and whether a treatment plan complying with this act has been implemented. If the patient no longer requires commitment to the facility in accordance with the standards for commitment, or if a treatment plan has not been implemented, he must be released immediately unless he agrees to continue with treatment on a voluntary basis.

Section 26. Care and treatment following release. The department of institutions and its agents have an affirmative duty to provide adequate transitional treatment and care for all patients released after a period of involuntary confinement. Transitional care and treatment possibilities include, but are not limited to, psychiatric day care, treatment in the home by a visiting therapist, nursing home or extended care, A HALF-WAY HOUSE, outpatient treatment, and treatment in the psychiatric ward of a general hospital.

Section 27. Treatment of children and young adults.

In addition to complying with all the other standards herein, a mental health facility shall make special provisions for the treatment of patients who are children and young adults. These provisions shall include, but are not limited to:

(a) Opportunities for publicly supported education suitable to the educational needs of the patient. This program of education must, in the opinion of the attending professional person be compatible with the patient's mental condition and his treatment program, and otherwise be in the patient's best interest.

(b) A treatment plan which considers the chronological, maturational, and developmental level of the patient.

(c) Sufficient professional persons, teachers, and staff members with specialized skills in the care and treatment of children and young adults.

(d) Recreation and play opportunities in the open air where possible and appropriate residential facilities, separate, wherever possible, from older patients.

(e) Arrangements for contact between the facility and the family of the patient.

Section 28. Records to be maintained. Complete patient records shall be kept by the mental health facility and shall be available to ~~anyone properly~~ ANY PROFESSIONAL

PERSON OR ATTORNEY authorized in writing by the patient AND THE BOARD. These records shall include:

(1) identification data, including the patient's legal status;

(2) a patient history, including, but not limited to:

(a) family data, educational background, and employment record;

(b) prior medical history, both physical and mental, including prior hospitalization;

(3) the chief complaints of the patient and the chief complaints of others regarding the patient;

(4) an evaluation which notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretative, fashion;

(5) a summary of each physical examination which describes the results of the examination;

(6) a copy of the individual treatment plan and any modifications thereto;

(7) a detailed summary of the findings made by the reviewing professional person after each periodic review of the treatment plan which analyzes the successes and failures of the treatment program and directs whatever modifications are necessary;

(8) a copy of the individualized after care plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;

(9) a medication history and status, which includes the signed orders of the prescribing physician. The staff person administering the medication shall indicate by signature that orders have been carried out;

(10) a detailed summary of each significant contact by a professional person with the patient;

(11) a detailed summary on at least a weekly basis by a professional person involved in the patient's treatment of the patient's progress along the treatment plan;

(12) a weekly summary of the extent and nature of the patient's work activities and the effect of such activity upon the patient's progress along the treatment plan;

(13) a signed order by a professional person for any restrictions on visitations and communications;

(14) a signed order by a professional person for any physical restraints and isolation;

(15) a detailed summary of any extraordinary incident in the facility involving the patient to be entered by a staff member noting that he has personal knowledge of the incident or specifying his other source of information, and initialed within twenty-four (24) hours by a professional person;

(16) a summary by the professional person in charge of the facility or his appointed agent of his findings after the fifteen (15) day review provided for in section 25.

Section 29. Records to be confidential — exceptions. All information obtained and records prepared in the course of providing any services under this act to individuals under any provision of this act shall be confidential and privileged matter. Such information and records may be disclosed only:

(1) in communications between qualified professional persons in the provision of services or appropriate referrals;

(2) when the recipient of services designates persons to whom information or records may be released, provided that if a recipient of services is a ward, and his guardian or conservator designates, in writing, persons to whom records or information may be disclosed, such designation shall be valid in lieu of the designation by the recipient; except that nothing in this section shall be construed to compel a physician, psychologist, social worker, nurse, attorney, or other professional person to reveal information which has been given to him in confidence by members of a patient's family;

(3) to the extent necessary to make claims on behalf of a recipient of aid, insurance, or medical assistance to

which he may be entitled;

(4) for research, if the department of institutions has promulgated rules for the conduct of research. Such rules shall include, but not be limited to, the requirement that all researchers must sign an oath of confidentiality;

(5) to the courts, as necessary to the administration of justice;

(6) to persons authorized by an order of court after notice and opportunity for hearing to the person to whom the record or information pertains and the custodian of the record or information pursuant to the rules of civil procedure;

(7) to members of the mental disabilities board of visitors or their agents when necessary to perform their functions as set out in section 30 of this act.

Section 30. Mental disabilities board of visitors — creation and responsibilities. (1) The governor shall appoint a mental disabilities board of visitors. The board shall consist of five (5) persons at least three (3) of whom shall not be professional persons and at least one (1) of whom shall be a representative of an organization concerned with the care and welfare of the mentally ill. No one may be a member of the board who is an agent or employee of the department of institutions or of any mental health facility affected by this act. If a board or similar title and

structure is created in any act concerning the treatment of the mentally retarded or developmentally disabled, then one board shall be created to perform the functions set out in both acts and the board so created shall include at least one (1) representative of an organization concerned with the care and welfare of the mentally ill and one (1) representative of an organization concerned with the care and welfare of the mentally retarded or developmentally disabled.

(2) The mental disabilities board of visitors shall be an independent board of inquiry and review to assure that the treatment of all persons either voluntarily or involuntarily admitted to a mental facility is humane and decent and meets the requirements set forth in this act.

(3) The board shall review all plans for experimental research involving persons admitted to any mental health facility to assure that the research project is humane and not unduly hazardous and that it complies with the principles of the statement on the use of human subjects for research of the American association on mental deficiency and with the principles for research involving human subjects required by the United States department of health, education, and welfare. No experimental research project involving persons admitted to any mental health facility affected by this act shall be commenced unless it is

approved by the mental disabilities board of visitors.

(4) The board shall, at least annually, inspect every mental health facility which is providing treatment and evaluation to any person pursuant to this act. The board shall inspect the physical plant, including residential, recreational, dining, and sanitary facilities. It shall visit all wards and treatment areas. The board shall inquire concerning all treatment programs being implemented by the facility.

(5) The board shall annually ~~inspect the treatment file of each person admitted to a mental health facility pursuant to this act to~~ insure that a treatment plan exists and is being implemented FOR EACH PATIENT ADMITTED OR COMMITTED TO A MENTAL HEALTH FACILITY UNDER THIS ACT. The board shall inquire concerning all use of restraints, isolation, or other extraordinary measures.

(6) The board may assist any patient at a mental health facility in resolving any grievance he may have concerning his commitment or his course of treatment in the facility.

(7) If the board believes that any facility is failing to comply with the provisions of this act in regard to its physical facilities or its treatment of any patient, it shall report its findings at once to the next of kin or guardian of any patient involved, the responsible person

appointed by the court for any patient involved, the professional person in charge of the facility, the director of the department of institutions, and the district court which has jurisdiction over the facility.

(8) The mental disabilities board of visitors shall report annually to the governor and shall report to each session of the Montana legislature concerning the status of the mental health facilities and treatment programs which it has inspected.

(9) The mental disabilities board of visitors shall be attached to the governor for administrative purposes. It may employ staff for the purpose of carrying out its duties as set out in this act.

Section 31. Standards for treatment to be known. Each patient and his next of kin, guardian, conservator, or the responsible person appointed by the court shall promptly upon the patient's admission receive written notice, in language he understands, of all the above standards for adequate treatment. In addition a copy of all the above standards shall be posted in each ward.

Section 32. Section 38-110, R.C.M. 1947, is amended to read as follows:

"38-110. Maintenance of indigent persons on discharge. ~~Upon~~ PRIOR TO the discharge of a patient from ~~the state hospital, the department~~ a mental health facility, the

professional person in charge of the facility shall notify the ~~board of public welfare~~ welfare department of the county from which the patient was committed. The ~~county board of public welfare~~ county welfare department shall at once ascertain whether the discharged patient is in financial need. If the patient is found to be in financial need, the ~~county board of public welfare~~ county welfare department shall properly care for and maintain the discharged patient under the ~~Public Welfare Act~~ laws of this state relating to public welfare until the patient is able to care for himself, or until another provision has been made for care of the patient."

Section 33. Section 38-212, R.C.M. 1947, is amended to read as follows:

"38-212. Cost of examination and commitment. The cost of the examination, committal, and taking ~~an insane person to the asylum~~ a person who is seriously mentally ill to a mental health facility must be paid by the county in which he resides at the time he is adjudged ~~insane~~ to be seriously mentally ill. The sheriff must be allowed the actual expenses incurred in taking ~~an insane person~~ a person who is seriously mentally ill to the ~~asylum~~ facility, as provided by section 16-2723 of this code."

Section 34. Section 38-506, R.C.M. 1947, is amended to read as follows:

"38-506. Support of patient ~~placed on convalescent leave, discharged by lapse of time~~ conditionally released. ~~(1)~~ When ~~the state hospital places a patient on convalescent leave,~~ a mental health facility conditionally releases a patient committed to its care, it is not liable for his support while ~~on convalescent leave~~ conditionally released. Liability devolves upon the legal guardian, parent, or person under whose care the patient is placed ~~on convalescent leave~~ WHEN CONDITIONALLY RELEASED, or upon any other person legally liable for his support. The public welfare officials of the county where the patient resides or is found, are responsible for providing relief and care for ~~the~~ a conditionally released patient ~~on convalescent leave~~ who is unable to maintain himself, or who is unable to secure support from the person under whose care he was placed on convalescent leave, like any other person in need of relief and care, under the public welfare laws. ~~The person under whose care the patient is placed on convalescent leave or any other person legally liable for his support, shall, if the convalescent leave is revoked, be liable for any expense incurred by the state or county in procuring the return of the patient to the hospital.~~

~~(2) The superintendent of the state hospital shall place on convalescent leave any patient under his control when he believes it is in the best interests of the patient~~

~~and society to do so. If a patient placed on convalescent leave is not returned to the institution within a period of two (2) years, he is considered discharged therefrom and entry shall be made accordingly in the records of the institution. If a patient who has escaped from the institution is not returned thereto within two (2) years, he is considered discharged therefrom and an entry shall be made accordingly in the records of the institution. When a patient is discharged whether by convalescent leave continuing for a period of two (2) years or by having escaped and not having been returned within two (2) years, the superintendent of the state hospital shall immediately notify in writing the judge of the court by which the patient was committed. A person so discharged may not be recommitted to the state hospital except by court order and upon proceedings as required by law for commitment in the first instance. This section does not restore the civil rights of persons so discharged or restore sanity, or relieve the superintendent of the state hospital from the obligation of supervising patients on convalescent leave to the extent of available facilities and finances."~~

Section 35. Section 38-507, R.C.M. 1947, is amended to read as follows:

"38-507. Clothing for patient on ~~convalescent leave~~ conditional release or discharged patient. A patient ~~or~~

~~inmate~~ may not be discharged or ~~placed on convalescent leave~~ conditionally released from ~~the state hospital~~ a mental health facility without suitable clothing adapted to the season in which he is discharged."

Section 36. ~~Section 80-1601, R.C.M. 1947, is amended to read as follows:~~

~~"80-1601. Institutions subject to per diem charge. The state department of institutions shall collect and process per diem payments for the care of residents in the following institutions and for the care of those persons in foster homes or other facilities for the mentally ill, or the mentally retarded, or developmentally disabled under provisions of the department:~~

~~(1) Montana children's center~~

~~(2) Warm Springs state hospital~~

~~(3) Boulder river school and hospital~~

~~(4) Galen state hospital~~

~~(5) Montana veterans' home~~

~~(6) Montana center for the aged.~~

~~(7) Eastmont training center."~~

SECTION 80-2501, R.C.M. 1947, IS AMENDED TO READ AS FOLLOWS:

"80-2501. Location and function of center. The institution located at Lewistown is the "Montana Center for the Aged". The primary function of the center is the care

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and treatment of ~~senile~~ persons who have been admitted to Warm Springs state hospital and subsequently transferred to the center. ~~As used in this chapter "senility" means mental illness resulting from the aging process.~~"

Section 37. Severability clause. If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

Section 38. Sections 38-107, 38-108, 38-109, 38-112, 38-113, 38-114, 38-115, 38-116, 38-201, 38-202, 38-203, 38-204, 38-205, 38-206, 38-207, 38-208, 38-208.1, 38-208.2, 38-208.3, 38-209, 38-211, 38-213, 38-401, 38-402, 38-403, 38-404, 38-405, 38-406, 38-406.1, 38-406.2, 38-407, 38-408, 38-408.1, 38-502, 38-503, 38-504, 38-505, and 64-112, R.C.M. 1947, are repealed.

-End-